U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 14 July 2004

In the Matter of

GEORGE T. KITANO
Claimant

v.

MARINE CORPS MWR/
CONTRACT CLAIMS SERVICE, INC.
Employer/Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Case Nos.: 2002 LHC 2948
2002 LHC 2949
2002 LHC 2950
2002 LHC 2951

OWCP Nos.: 15-34238
15-45067
15-45564
15-46015

Appearances: Mr. Steven M. Birnbaum, Attorney
For the Claimant

Mr. Robert C. Kessner, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER -
PARTIAL AWARD OF TEMPORARY TOTAL DISABILITY COMPENSATION;
AWARD OF PERMANENT PARTIAL DISABILITY COMPENSATION & PENALTIES;
PARTIAL AWARD OF MEDICAL BENEFITS

This case involves several claims filed by Mr. George Kitano for disability compensation and medical benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901 to 950, as amended ("Act"), as made applicable by the Non-Appropriated Fund Instrumentalities Act, 5 U.S.C. §§ 8171 to 8173. In September 2002, through counsel, Mr. Kitano filed a pre-hearing statement seeking disability compensation and medical benefits for multiple injuries to his right knee, left knee and both shoulders that he suffered while working for, and due to his employment with, the Marine Corps Morale Welfare and Recreation ("MWR") Non-Appropriated Fund Instrumentality ("Employer") at the Kaneohe Marine Corps Base, Oahu, Hawaii (EX 62).[1] On September 25, 2002, the District Director forwarded the pre-

[1]The Employer's counsel submitted a pre-hearing statement on November 19, 2002 contesting Mr. Kitano's entitlement to disability compensation and medical treatment for the claimed injuries (EX 63).

hearing statement to the Office of Administrative Law Judges. After one continuance, and pursuant to a Notice of Hearing, dated February 20, 2003 (ALJ I),[2] I conducted a formal hearing on May 12 and 13, 2003 in Honolulu, Hawaii, attended by Mr. Kitano, Mr. Birnbaum, and Mr. Kessner. My decision in this case is based on the hearing testimony and all the documents admitted into evidence: CX 1 to CX 3,[3] CX 5 to CX 7,[4] EX 1 to EX 83.

ISSUES[5]

A. Right Shoulder Injury/Cumulative Bilateral Shoulder Injury

1. Timely notice and claim

2. Causation

3. Nature and extent of disability, and disability compensation

4. Medical benefits

B. Left Shoulder/Cumulative Bilateral Shoulder Injury

1. Causation

2. Nature and extent of disability, and disability compensation

3. Medical benefits

C. Right Knee Injury/Cumulative Bilateral Knee Injury

1. Nature and extent of disability, and disability compensation[6]

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[2]The following notations appear in this decision to identify exhibits: CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

[3]At the hearing, I received and admitted a binder of exhibits, marked CX 1 to CX 6. Upon adjudication of this claim, I discovered that although CX 4 is identified in the exhibit list as "Responses to Discovery. . .pages 31-587," no documents were located behind the tab labeled "CX 4."

[4]At the conclusion of the hearing, I left the record open for receipt of Dr. Gary Y. Okamura's deposition and to provide Mr. Birnbaum an opportunity to respond to additional surveillance tape footage. I subsequently received, and now admit as CX 7, Dr. Okamura's July 1, 2003 deposition.

[5]In his closing brief, page 3, counsel for the Claimant stated: "Claimant raised a claim of cumulative injury to the shoulders when he transferred to lighter duty in 1994 and thereby suffered a substantial wage loss but finds the issue more appropriately addressed by filing a new claim with the OWCP and thereby withdraws this claim." Based on that representation, I need not address the compensation rate issue.

[6]The nature and extent of disability inquiry will also address periods of any temporary disability and credit to the Employer/Carrier for benefits previously paid.

2. Medical benefits

D. Left Knee/Cumulative Bilateral Knee Injury

1. Timely notice of claim

2. Causation

3. Nature and extent of disability, and disability compensation

4. Medical benefits

Parties' Positions

Claimant[7]

An employee of the Marine Corps MWR at Kanehoe Marine Corps Base for twenty-five years, Mr. Kitano last worked for the Employer as a golf course maintenance laborer. In that capacity, Mr. Kitano was required to accomplish overhead work and periodic lifting of up to fifty pounds.

Mr. Kitano injured his right shoulder in 1990. When he returned to work, the Employer did not accommodate his work restrictions. His right shoulder condition worsened and his left shoulder developed a cumulative injury. Due to his problem, upon the advice of his physician, Mr. Kitano took a voluntary transfer to a part time job in 1994 with a reduction in hourly income of $4. Although Mr. Kitano never filed a claim for the left shoulder, the Employer knew or should've have known about his left shoulder problem because of the 1994 job transfer. Based on that knowledge, the Employer should have filed a first report of injury. Since the employer did not file that report, the statute of limitations has not started and Mr. Kitano may make his claim for a cumulative injury to his left shoulder at this time.

In June 2000, Mr. Kitano injured his right knee. Prior to that time, he did not have any problems or pain in his right knee. After surgery on his right knee, Mr. Kitano returned to work; however, the knee did not return to normal. He continues to experience significant pain in the knee and has a permanent impairment. If further compensation is due, then the Employer must be assessed penalties.

Due to his right knee pain, and continued hard labor at work, Mr. Kitano principally relied on his left knee. That overuse has caused pain in the left knee. He claims an injury to the left knee as of October 2001.

On July 26, 2002, Mr. Kitano's physician removed Mr. Kitano from work. At that time, he was experiencing pain in his left shoulder. He stopped working due to cumulative injuries in his shoulders and left knee.

[7]TR, pages 8 to 18, 23, 24, 33, 39, 290, and closing brief, dated September 3, 2003.

Through credible complaints of pain and medical opinion, including the assessment of a treating physician, Mr. Kitano has invoked the Section 20 (a) presumption that Mr. Kitano's disabling conditions were caused by his employment. The biased opinion of the Employer's examining physician does not rebut that causation presumption. According to his treating physician, Mr. Kitano is totally disabled due to shoulder and knee pain. At least two physicians believe additional medical treatment options are available for both Mr. Kitano's knees and shoulders. Consequently, he has not reached maximum medical improvement ("MMI"). The Employer has not presented any evidence of suitable alternative employment.

Mr. Kitano seeks temporary total disability compensation for his injuries, related medical treatment and benefits, and attorney fees.

Employer[8]

Concerning the September 1990 right shoulder injury, the problem was really a pre-existing cervical condition. Mr. Kitano received temporary total disability compensation for a period of time and then returned to work. This disability claim closed on July 9, 1991 and no basis exists for permitting a further claim for benefits. Although one physician found a permanent impairment due to the injury, another doctor disagreed and found no permanent disability. Additionally, beyond the already paid periods of temporary total disability, Mr. Kitano suffered no other loss of wage earning power. In regards to medical benefits, the Employer notes that for ten years after July 1991, Mr. Kitano did not require any medical treatment for his right shoulder. Any further medical treatment for the right shoulder is not related to the September 1990 accident. In 1994, Mr. Kitano voluntarily transferred to a part-time job with the Employer.

The accident of June 18, 2000 only temporarily aggravated the pre-existing osteoarthritis in Mr. Kitano's right knee. Mr. Kitano reached maximum medical improvement on October 4, 2001 and any remaining symptoms relate to his pre-existing, though possibly asymptomatic, age-related arthritis. The accident did not cause a permanent impairment in the right knee; any current impairment is due to arthritis. Likewise, no further medical benefits are warranted since any additional care is related to the pre-existing arthritis.

No work-related risk factor existed to cause Mr. Kitano's left knee problems. Degenerative joint disease is the cause of his pain. The claimed altered gait due to the right knee injury of June 2000 is dubious. Accordingly, neither disability compensation nor medical benefits are appropriate.

Although Mr. Kitano had claimed a cumulative injury to his left knee in October 2001, he continued to work. Prior to the hearing, Mr. Kitano had not claimed that his cumulative left knee injury forced him to stop working in May 2002. He first made that claim at the May 12, 2003 hearing. Such notice is untimely. Additionally, as mentioned above, Mr. Kitano's left knee condition is attributable to arthritis. As a result, the claim for a cumulative left knee injury is not a compensable claim under the Act.

[8]TR, pages 18 to 24, 39, and closing brief, dated August 29, 2003.

The medical evidence does not support the claim for a cumulative bilateral shoulder injury. In the later years of his employment, Mr. Kitano had no problems with his upper extremities while working at the golf course. Medical opinion also establishes that Mr. Kitano's shoulder problems are due to his degenerative arthritis and not his work environment. Surveillance films also demonstrate that Mr. Kitano has no problems carrying items or using his upper extremities to build wooden frames. Additionally, Mr. Kitano is presently performing physical work for friends and his attorney similar to the tasks he also accomplished at the golf course. He could return to his former job at the golf course. Consequently, Mr. Kitano is not entitled to either disability compensation or medical benefits.

SUMMARY OF EVIDENCE

While I have read and considered all the evidence presented, I will only summarize below the information potentially relevant in addressing the issues.

Mr. George T. Kitano

Deposition — January 30, 2003
(EX 69)

Mr. Kitano was born on April 15, 1928 and is 74 years old. After graduation from high school, he completed an automobile technical course and worked in various automotive and body shops. Mr. Kitano also has worked in restaurants, construction, vehicle maintenance, and as a mail carrier. In 1977, he started working at the Marine Corps base in maintenance.

During September 1990, Mr. Kitano was a maintenance leader who assisted the supervisor. His job involved a wide array of tasks including plumbing, carpentry, jack hammering, painting, and "everything." He overused his right shoulder when drywalling, sanding and painting a ceiling in a building by himself. Due to the pain, he saw a doctor at Kaiser hospital who discovered that Mr. Kitano had shoulder pain when he raised his arm. The doctor told him that he had a 22% disability. Following the injury, Mr. Kitano, who is right-handed, had to rely more on his left shoulder. In 1994, Mr. Kitano took a downgrade after he requested light duty due to his right and left shoulder problems. At that time, he was transferred to the golf course for light duty. Prior to stopping work in 2002, Mr. Kitano had worked as an attendant in the golf cart barn for about two years.

In June 2000, before dawn, Mr. Kitano was washing golf balls in a machine that discards debris and rocks into a barrel. He stepped on one of the rocks and twisted his right knee. He felt "bad pain" but finished his work day and then went to the emergency room because it was a Sunday. The doctor took an x-ray and then referred him to another physician, Dr. Sandor. The x-ray didn't show what was wrong; Dr. Sandor prescribed pain killers and physical therapy. Then, he went to a specialist who said his right knee was "cracked." He had arthroscopic surgery. He accomplished more physical therapy. However, his knee pain continued. Dr. Sandor told him it was degenerative arthritis. At present, his right knee is painful.

Sometime after his knee injury, Mr. Kitano returned to light duty as a checker. At the number one tee, he checked golfers' receipts and recorded their cart numbers. He sat on a golf cart to do his work. After about a month as a checker, Mr. Kitano returned to his golf cart attendant work. In that position, he kept moving from cart to cart to recharge their batteries. Due to that effort and his painful right knee, he put more pressure on his left knee and it started getting painful. Nothing really happened on October 4, 2001. Mr. Kitano just claimed that date because his left knee pain was gradually building up. He told his supervisor that he wanted to file a claim about his left knee. Eventually, he went to see Dr. Hager about his problems. Dr. Hager recommended pain killers and sent him to Dr. Okamura.

In May 2002, Mr. Kitano was still a golf cart attendant. Over the years, all his jobs and his present duties of lifting, unwinding electric cords, and fixing cart flat tires caused problems with his shoulders. He told his supervisor about his sore shoulder. His left shoulder has problems because he nursed his right shoulder and extensively used his left shoulder "all these years." His right shoulder pain stops him from using that shoulder. He has seen Dr. Hager and Dr. Okamura about his shoulders. He stopped working in October 2002 on Dr. Hager's advice.

At present, Mr. Kitano does little minor repairs at home and is able to drive.

Hearing Testimony – May 2003
(TR, pages 118 to 194)

[Direct examination] Prior to working for the Marine Corps, Mr. Kitano was employed as a construction worker for several years and a letter carrier for seventeen years. He has been with the Marine Corps for more than 25 years. Technically, he still works for the Marine Corps because he has not yet retired. With the Marine Corps, he started as a maintenance worker and was promoted to shop leader about three years later. As a shop leader, he still performed heavy labor which included busting cement and walls. He did not become a manager since he was active in the union as a chief steward. From Mr. Kitano's perspective, the more assertive he became defending union members in adverse action proceedings, the more management targeted him to make his work harder. This type of management practice occurred prior to his 1990 injury.

In 1990, he was assigned a large room to sandpaper and paint. He had to use a big scaffold. Next, management assigned him to drill holes with a concrete drill without any help. Then, Mr. Kitano had to erect a children's jungle gym which required him to dig a hole for a big post. All these activities gradually increased the pain in his shoulder until he could no longer stand the pain. So, he reported the shoulder injury as a result of the jungle gym work. When he first reported the injury, they sent him to some doctor. Later, using his own medical insurance, Mr. Kitano went to the Kaiser hospital. Mr. Kitano does not recall the doctors' names. The pain was in his shoulder and not his neck. He does recall a neck problem but he doesn't remember what caused it.

After some time off, Mr. Kitano returned to regular work. Because he couldn't stand the pain and the pills and was still being assigned tasks to complete by himself, Mr. Kitano asked for a transfer to light duty. Before the transfer, he continued to have pain in his shoulder and neck.

When he made his request, Mr. Kitano told management it was due to his "shoulder's pain." Mr. Kitano believes management approved his transfer to get rid of him. So, in 1994, he moved to the pro shop at the golf course. At first, he cleaned up and performed minor maintenance work. After about nine months, he transferred to the golf cart barn. In both jobs, he worked full time. However, after he turned 65 and applied for social security, he received a notice that he had to reimburse several thousand dollars to the government due to his full time status. As result, Mr. Kitano went to a part-time schedule.

Mr. Kitano is responsible for about 100 golf carts. Starting at 5:00 a.m., he worked three days a week, seven hours a day for a weekly total of 21 hours. He worked with a partner who had a bad knee so they split up the tasks. While his partner unplugged the carts from the chargers, Mr. Kitano used a gas blower to clear the patio area. The blower weighed about 18 pounds. The task took about 30 minutes and the blower would get heavy. His arm would become tired. He then scrubbed out the golf club washer and refilled it. Next, Mr. Kitano and his partner went out to the three golf course water stations and put out a five gallon cooler of water and ice. They made this trip two to three times a day. His partner also used a tractor to rake in the golf balls from the driving range. In the meantime, Mr. Kitano retrieved golf balls in the bushes by hand. After collecting the golf balls, Mr. Kitano and his partner would lift the heavy buckets containing the golf balls and put them in the ball washing machine. The range collection buckets weighed about 18 pounds. After washing, they would take the five gallon buckets of balls to the pro shop. At the pro shop, Mr. Kitano and his partner would have to lift the bucket and dump the balls into a larger bucket. Sometimes, Mr. Kitano emptied the wet ball bucket by himself; it could weigh about twenty pounds. They did that task about three times a day. Also, when a golf cart returned to the barn, Mr. Kitano would unwind the overhead electric recharging cable and plug it into the golf cart. Throughout the day, he'd accomplish that task for 40 to 50 golf carts. If a golf cart had a flat tire out on the course, Mr. Kitano would replace it using a hydraulic jack and spare tire. He had to kneel to change the tire and sometimes push the cart to firmer ground. On occasion, they would tow the cart back to the barn, especially if the ground wouldn't support the jack. These types of situations occurred often but not every day. Finally, when Mr. Kitano emptied the trash, he had to lift it up to about five feet to place it inside the receptacle. Sometimes the trash bags weighed 25 to 30 pounds. Mr. Kitano and his partner accomplished most of these jobs without supervision. Usually, he saw his supervisor only when a tournament was going on.

When Mr. Kitano stopped working, his shoulders were "always bad." He's not really sure of the date; it's either summer or fall of 2002. At that time, the pain in his shoulder was persistently about a four or five level of pain. The overhead work didn't bother his shoulder, carrying the heavy bucket of wet golf balls required him to use his hip and knee to dump the balls. However, generally, "when you're in a lot of pain, you forget about the pain, because you are doing a job." Staying busy helped him forget about the pain. The right shoulder pain did not get worse; it stayed about the same.

The left shoulder pain, at a level of seven to nine, causes Mr. Kitano to "rely mostly on my right shoulder now."

His shoulder pain coupled with his "right knee" played a role in his departure from work. If he did not have knee pain, Mr. Kitano could have continued to work with only the shoulder pain. The two problems combined forced him off work.

On June 18, 2000, Mr. Kitano twisted his right knee when debris from a washing basket fell on the dock area. He didn't fall down and continued working. However, the injury caused him to hobble. After work, he went straight to Kaiser emergency room. First, he was referred to physical therapy for several months. During this period, he still did some work. The physical therapy didn't help; he considered it a waste of time. So, Mr. Kitano went to the hospital for an arthrogram of his knee. The test revealed a "crack" on his knee and he had knee surgery. He was off work while recovering from the surgery and during additional physical therapy. However, his condition still didn't improve; he still had pain. Prior to the accident, Mr. Kitano did not have any pain in, or problems with, his right knee. "It was normal."

When he returned to work, the doctor indicated that he should not climb the hill to retrieve balls and his supervisor told him not to do that. "But, yet, once in a while, there's too many balls out there, on the hill. So I kept on doing it." Mr. Kitano doesn't recall whether the physician told him not to kneel. He was given a weight lifting restriction of 25 pounds. But, many times at work, he had to lift more than 25 pounds. For example, lifting the ball buckets, that was part of his job.

Sometimes his right knee is worse. About a month ago, after sitting down watching his grandchildren play soccer, he rose up and couldn't take another step due to his right knee. He received help, was eventually able to drive home and got on his crutches. The worse level of pain in the right knee is seven to eight. Swimming seems to help it. He takes some pain medication that helps.

Mr. Kitano's left knee gets tired. According to Mr. Kitano, "My left knee is always – it's got problems, but I rely too much on my left knee, getting tired. Off and on. . . Once in a while, there's pain. But, mostly my left knee is tired." The left knee is not weak. He just has to rest it some times. Dr. Okamura examined his knees. He doesn't recall what the doctor was going to do for his left knee. However, Mr. Kitano wants some medical care for his knees. The pain level in his left knee is "about two, three. It's just tired. It's not that severe."

Mr. Kitano has reviewed the surveillance video. He built the small wooden frame with a concrete block to hold up a clothes line for a friend. It weighed about 20 pounds. He carried the frame. While carrying it, he didn't think about how heavy it was. He just had to carry it. He doesn't do that kind of activity often. Usually, he stays home and does nothing. The other pictures show Mr. Kitano taking care of his attorney's house, cleaning, vacuuming, taking care of minor maintenance. Going up and down the stairs was painful.

Mr. Kitano went to Dr. Hager based on Mr. Birnbaum's recommendation. The doctor evaluated his shoulders. Mr. Kitano doesn't recall the diagnosis. Dr. Hager prescribed some medication. However, Mr. Kitano stated, "he wrote a prescription, but I didn't go through a pharmacist. And he says, 'How's it feel?' And I said, 'Oh, it's working.' But I didn't take it." He is presently having problems with his medical insurance billing concerning his knee surgery.

The amount due is about $82. Additionally, Mr. Kitano had a bad experience with the pain medication prescribed by Dr. Van Meter.

Dr. Hager recommended that he stop work. Mr. Kitano agreed and the physician notified the Employer. He has been using his sick leave. Mr. Kitano has not received any workers' compensation. After his knee surgery, the Employer offered him an alternative job. Since he has been out of work for his shoulders, the Employer has not offered alternative work.

Mr. Kitano can't go back to work because he is afraid of carrying heavy things many times a day. Prior to being injured, he did not have any retirement plans. He enjoyed working.

[Cross examination] Mr. Kitano used a table saw to cut the material for the wood frame; he put it together with a hammer and nails. He also mixed the concrete for the footing and used a cinder block. He carried the frame in his truck. His leg doesn't bother him when driving.

If Mr. Kitano had not gone to Dr. Hager, no one would have helped him with his medical problems. He also would probably still be working.

Mr. Todd Murata
(TR, pages 212 to 219 and EX 75)

[Direct Examination] Mr. Murata is the golf course manager at the Marine Corps base. Mr. Kitano worked as a cart/range attendant. In that capacity, he was responsible for transporting carts from the cart storage facility to the staging area at the pro shop. Each shift required him to move 30 to 50 carts. He also drove a tractor with an attached picker on the driving range, collecting golf balls. After gathering the golf balls, Mr. Kitano would return to the cart storage area and place the balls in a ball washing machine. Typically, he worked with a partner. Usually, each work shift has two cart/range attendants working together. They assist each other and carry ball baskets together.

Mr. Murata has observed Mr. Kitano perform his work at the golf course. He also reviewed the surveillance video. He did not see anything in the film that was inconsistent with Mr. Kitano's work at the golf course.

[Cross examination] Mr. Murata did not have the same schedule as Mr. Kitano. Mr. Kitano starts his work day around 5 in the morning. Mr. Murata arrives between 8:30 and 9:00 a.m. Consequently, Mr. Murata did not observe his early morning activities on the golf course.

Mr. Murata's office overlooks the staging area, which is in a different location than the cart barn. However, he spends most of his time out of the office, walking around the facility. Mr. Murata has 65 employees. He did not directly supervise Mr. Kitano. As a result, he did not observe Mr. Kitano on a consistent basis.

[Affidavit] Mr. Murata has supervised Mr. Kitano since June 1999. Mr. Kitano is one of ten cart attendants at the golf course. Although he complained about aches and pain, Mr. Kitano

never reported any physical problems due to his work duties. Mr. Kitano last worked at the golf course on July 26, 2002.

Dr. Catherine A. Bender
(EX 3, EX 5, and EX 74)

September 24, 1990 -- At the Kailua Clinic, Mr. Kitano presented to Dr. Bender with right shoulder pain and hand numbness. He was engaged in overhead construction work, which included painting and sanding. According to Mr. Kitano, his right shoulder pain started five days earlier; the numbness developed sometime later. Dr. Bender observed that movement of Mr. Kitano's neck to the left caused right scapular[9] pain. Mr. Kitano had full range of motion in his shoulder joints. The right trapezius[10] muscle over the scapular was tender. His strength was intact. At the same time, Mr. Kitano had diminished sensation to light touch in his right fingers. Dr. Bender diagnosed Mr. Kitano with right trapezius muscle strain, with the possibility of nerve impingement. She prescribed heat therapy and motrin. She indicated he could return to work on October 3, 1990. A cervical spine x-ray taken the same day revealed minimal narrowing of the C5-6 disc space with "untinate spurring impinged upon the right C5-6 neural foramen." The diagnosis was mild degenerative change at the C5-6 disc.

October 2, 1990 -- When she examined him again, Mr. Kitano reported no relief from the prescribed therapy. Although he had full range of motion in his shoulders, Mr. Kitano still experienced right scapular and upper arm pain and finger numbness. Her examination produced the same results. Dr. Bender diagnosed trapezius muscle strain and considered nerve impingement.

Dr. Shankar Bhat
(EX 6, EX 7, EX 12, EX 14, EX 15, EX 17 to EX 19, and EX 74)

October 12, 1990 -- Dr. Bhat evaluated Mr. Kitano's shoulder problem based on a referral from Dr. Bender. Mr. Kitano was experiencing pain in the right scapula and arm with numbness in several fingers of the right hand. During the course of overhead work, Mr. Kitano had developed the presenting symptoms. He was not responding to non-steroidal, muscle relaxant, and anti-inflammatory medication. A C-spine x-ray showed "mild degenerative changes at C5-6." Mr. Kitano reported no direct injury to his right shoulder. Upon physical examination, Dr. Bhat found some tenderness on palpitation of the lateral trapezius on the right side. The range of motion at C5 was within normal limits. Likewise, the right shoulder's range of motion was normal. No significant tenderness was located in the right arm or shoulder, other than some tenderness along the line where the radial nerve runs along the arm. Dr. Bhat diagnosed cervical radiculopathy and degenerative cervical spine, C5-6. He believed an EMG was necessary to rule out nerve entrapment in the C-spine. He also scheduled physical therapy

[9]Muscle/ligament just below the trapezius muscle group. *Id.*

[10]The outer most, upper shoulder muscle group. DORLAND'S ILLUSTRATED MEDICAL DICTIONAY 1069 (28th ed. 1994).

for the right shoulder and arm. Mr. Kitano was released to limited duty with the restriction to avoid using his right arm and shoulder.

November 30, 1990 -- Dr. Bhat again examined Mr. Kitano, who had been placed off work since the Employer did not have any limited duty for him. Mr. Kitano wanted a change in duty status so he could get paid. Dr. Bhat noted that a recent EMG found a questionable motor deficit at one particular level. An MRI of the C-spine had been recommended. Mr. Kitano reported continued right shoulder pain and radiating arm pain. He had difficulty accomplishing strenuous work with his right hand. Upon physical examination, the doctor found no acute distress. Mild tenderness existed over the right shoulder. The right shoulder range of motion was normal. Dr. Bhat continued to diagnose cervical radiculopathy with degenerative changes at C5-6. Since he believed the EMG showed some abnormalities and Mr. Kitano still had radiating pain, Dr. Bhat recommended an MRI. He continued Mr. Kitano's work restrictions.

January 21, 1991 -- Mr. Kitano had another check-up with Dr. Bhat. Radiating right shoulder and arm pain was still present. Mr. Kitano indicated that if he avoided heavy lifting, his symptoms remained unchanged. He was "relatively comfortable managing his work so he has still been on limited duty." During the examination, Mr. Kitano did not have any significant tenderness in the cervical muscles. However, with extreme rotation of his neck to the left, he experienced mild pain on the right side of the neck.

February 25, 1991 -- Mr. Kitano returned to Dr. Bhat and reported improvement in his condition. Although he still felt some numbness and tingling sensation in his right arm, he did not have any significant pain in his neck and no longer experienced weakness in his right hand. He had been able to remain at work in a limited duty capacity. Upon examination of the neck, Dr. Bhat found no tenderness and the range of motion was normal. The range of motion of the right arm and shoulder was also normal. Pain and touch sensations were normal. Mr. Kitano experienced some pain in the right shoulder when he raised his arm about shoulder level. Dr. Bhat described the symptom as myofacial. Dr. Bhat diagnosed degenerative C-spine disease and possible cervical radiculopathy. He noted that Mr. Kitano is not able to have an MRI. Pending an additional check-up, Dr. Bhat kept Mr. Kitano in limited duty status.

March 25, 1991 -- Mr. Kitano presented to Dr. Bhat with continuing pain sensation in his right forearm and some right hand weakness. He was working limited duty at the golf course and noticed the hand weakness when moving golf bags. The numbness was no longer present. Upon examination, the cervical area was generally normal with some right lateral limitation due to discomfort. Mr. Kitano's grip strength "appears to be equal and normal in both hands." Since Mr. Kitano appeared to be adjusting well, Dr. Bhat kept him on limited duty.

July 30, 1991 -- Dr. Bhat annotated that Mr. Kitano's pain remained the same; he did not have any other problems. Apparently, his employer was willing to let him remain in limited duty status. The physical examination results, diagnosis, and limited duty status remained the same.

September 24, 1991 -- Dr. Bhat again evaluated Mr. Kitano. Mr. Kitano reported he had "been able to manage" with conservative treatment and exercises. He had one and a half years to go on his job and wanted to continue. Mr. Kitano did not have any new symptoms. He was not

weak and did not have any neurological symptoms. Other than some pain with range of motion of the left shoulder, the examination was normal. Dr. Bhat diagnosed cervical radiculopathy with continued neck pain. Dr. Bhat prescribed exercise and limited duty.

December 6, 1991 -- Dr. Bhat's follow-up examination produced no significant changes. While still having numbness in his right arm, Mr. Kitano "has found suitable work for his work situation at limited duty status and he is well adjusted to that and comfortably continuing with that limited duty status." With one exception, Mr. Kitano did not have any new or worsening symptoms. He reported that "he has been using his left shoulder more so since his problem is on the right side so he has gradually noticed increasing discomfort in the left shoulder now, particularly when he moves his left arm backwards." The examination of the neck and shoulders did not produce any significant changes in findings. Dr. Bhat did find some mild muscular tenderness over the shoulders, "more so on the left side." He diagnosed cervical radiculopathy with chronic neck pain and advised Mr. Kitano to keep his limited duty status. Dr. Bhat believed Mr. Kitano's condition had stabilized and that he was ready for a disability rating.

February 4, 1992 -- Dr. Bhat conducted his final examination of Mr. Kitano. Mr. Kitano reported some "slight discomfort" in the right side of his neck and right arm. He is comfortable with a 40 hour week at limited duty. The physical examination was "essentially unremarkable" with no evidence of local tenderness. All ranges of motion were normal. Dr. Bhat diagnosed chronic neck pain, recommended a referral for a disability rating, continued the limited duty restrictions, and discharged Mr. Kitano from his care.

Physical Therapy
(EX 74)

October 22 and October 31 , 1990 -- Mr. Kitano presented for physical therapy with pain from his right shoulder blade to fingers with a tingling sensation in his fingers. In the second session, Mr. Kitano reported some improvement in his pain condition.

November 9 to November 30, 1990 -- Mr. Kitano received four sessions of physical therapy. While the four treatments improved range of motion and reduced the level of pain, Mr. Kitano still experienced numbness in his right arm. At the end of the sessions, Mr. Kitano indicated that he was returning to work in a light duty status.

Dr. Coswin Saito
(EX 11, EX 12, and EX 74)

Mid-November 1990 -- Dr. Saito conducted an EMG study of Mr. Kitano's upper right extremity. Mr. Kitano explained that he had to do considerable work with both upper extremities, plastering, sanding, and painting. Without an antecedent trauma, Mr. Kitano began to experience pain in his right arm, right shoulder, and neck in the late summer, early fall, of 1990. The right shoulder pain and a tingling sensation radiated down his forearm into the middle and ring fingers of his right hand. Although his right arm was not weak, it fatigued easily. According to Mr. Kitano, he had "no left upper extremity symptoms." During the physical examination, Dr. Saito reported Mr. Kitano had "full painless range of motion of his neck and

upper extremities." He had full strength in both upper extremities. His sensation was intact throughout the upper extremities. Upon completion of the EMG test, Dr. Saito found no evidence of a cervical radiculopathy. At the same time, the EMG indicated Mr. Kitano may nevertheless have a sensory, rather than motor, C-7 cervical radiculopathy. Dr. Saito recommended an MRI to rule out a disc problem at C-7.

Dr. Stuart Pang
(EX 16 and EX 74)

April 9, 1991 -- Based on a referral from Dr. Bhat, Dr. Pang conducted a consulting examination. Dr. Pang noted Mr. Kitano experienced numbness and tingling in his right hand and "dull, unbearable ache in the ulnar aspect of his right hand, right forearm, and elbow area." After an EMG was administered, "no evidence of cervical radiculopathy was felt to be present." The nerve conduction test was also normal. Due to a foreign object in his eye, an MRI is not possible. Mr. Kitano reported mild improvement with physical therapy. He generally feels better. However, "occasionally if he overworks his right upper extremity such as prolonged elevation of his left upper extremity over his head he notes that he will have increased symptoms." He reported no weakness in his right upper extremity. Upon examination, the cranial nerve was intact. Motor evaluation showed "excellent tone, bulk, and symmetrical strength throughout." No atrophy was present. "The cervical spine x-ray showed mild degenerative changes at C5-6 disc space with some spurring upon the right C5-6 neural foramen." Dr. Pang diagnosed probable cervical radiculopathy, despite the normal EMG. Mr. Kitano "adamantly" declined any neurosurgical treatment. As a consequence, Dr. Pang did not recommend a myleogram unless Mr. Kitano's symptoms increased. Dr. Pang gave Mr. Kitano the following advice: "he should not be lifting heavy objects with his right hand, not overworking the right arm with repetitive movements at the shoulder or with sudden movements of his neck, or prolonged lifting over his head of the right upper extremity."

Dr. Gervase Flick
(EX 74)

June 18, 1991 -- Dr. Flick evaluated Mr. Kitano's periodic right arm numbness and his duty status. The doctor noted that Dr. Bhat had been treating Mr. Kitano for degenerative cervical spine disease and radiculopathy. Dr. Bhat believed Mr. Kitano would never be able to return to full duty status. Mr. Kitano had refused recommended surgery. In particular, "the risks vs. benefits of continuing in this condition had been repeatedly explained to him. He fully realizes it but still refuses any surgical intervention." Mr. Kitano explained that "he only has two years to finish his work and wants to finish it out on his limited duty status." Dr. Flick explained "the numbness may be progressive along with some weakness of grip." However, Mr. Kitano indicated that "he is willing to take his chances with such."

Upon examination, Dr. Flick found "minimal tenderness of the right lateral superior border of the trapezius but demonstrates quite good right shoulder range of motion and left shoulder range of motion per age and condition." Dr. Flick diagnosed cervical radiculopathy and degenerative cervical spine disease. He recommended permanent limited duty and condition monitoring by Dr. Bhat.

Dr. Gabriel W. C. Ma
(EX 20 and EX 21)

February 12, 1992 -- Dr. Ma, board certified in orthopedic surgery, examined Mr. Kitano. Prior to this examination, Dr. Ma had reviewed about 45 minutes of videotaped activities by Mr. Kitano;[11] he also reviewed a portion of the medical record. From the medical record and Mr. Kitano, Dr. Ma learned that around September 4, 1990, Mr. Kitano developed pain in his right shoulder area and right arm while doing overhead sanding and painting. He also experienced numbness of the right upper extremity. Mr. Kitano recalled no direct injury to his right shoulder. By September 24, 1990, the pain was sufficient to stop Mr. Kitano from working. He attempted to return to work on October 5, 1990 but continued to have problems with his right shoulder. He was told to go home and not return until he felt better. Dr. Bhat treated him with non-steroidal anti-inflammatory drugs, muscle relaxants, and physical therapy. An x-ray of the cervical spine showed mild degenerative changes at the C5-6 level and Dr. Bhat suspected cervical radiculopathy. Dr. Ma believes those degenerative changes were pre-existing. An EMG was "essentially normal" but showed some sensory findings for the C-7 nerve. Dr. Bhat eventually returned Mr. Kitano to light duty. Due to the light duty restriction, Mr. Kitano was assigned to the golf course and maintained equipment. Mr. Kitano enjoyed the work and indicated that he did not want to return to heavy duty work anymore; he intended to retire in a couple of years.

At the time of the examination, Mr. Kitano reported continued pain on the right side of his neck, right shoulder blade area; numbness in the right forearm; and, tingling sensation in the ring and little fingers of his right hand. Whenever he engaged in heavy labor, the right hand numbness increased. Upon physical examination, Mr. Kitano had muscle tightness in his upper trapezius muscle and vertebral border of the scapula. He suffered loss of motion laterally and backwards, which Dr. Ma considered to be a 10% whole person impairment.

Dr. Ma interpreted the cervical x-rays and diagnosed a degenerated, herniated C5-6 disk "with an osteophytic encroachment onto the C5-6 disk space, particularly on the right side of a minor degree which is equivalent to 4 percent impairment of the man with an unfavorable degenerative change." According to Dr. Ma, the combined "stationary" impairment rating was 14%.

Dr. Ma found "no obvious sensory deficit." Mr. Kitano's subjective pain and numbness complaints fit "in well with the C-6 nerve root distribution of disk herniation and minor radiculopathy of the C-6 nerve."

Mr. Kitano's hand grips were normal. His forearm muscles were symmetrical. The range of motion of the low back was normal.

Other than the radiological evidence of the degenerated, herniated C5-6 disk, Dr. Ma found no other sensory or neurological deficits. Based on the medical record review, physical examination and x-ray review, Dr. Ma reached the following conclusion:

[11]At the conclusion of his report, Dr. Ma indicated that the videotape did not help him to reach any conclusions.

> [T]his gentleman certainly had gradual pre-existing degenerated C5-6 disk with minor osteophytic encroachment onto the intervertebral foramina at the C5-6 level on the right side affecting the symptom complex which he complained of which is quite classical for a person who has a gradual degenerated and herniated C5-6 disk.

Due to his condition, Dr. Ma recommended that Mr. Kitano remain in light duty until he reaches retirement age within the next couple of years. Such an assignment would avoid aggravation of his degenerated C5-6 disk. Additionally, absent such aggravation, Mr. Kitano would most likely not need any "specific medical attention or have any further investigative measurements to conclude a diagnosis." Concerning etiology, Dr. Ma believed Mr. Kitano did not suffer any specific incident in September 1990 that caused his symptoms. Instead, Mr. Kitano's "symptom complex" had been "gradually developing" and "finally manifested" in September 1990. Mr. Kitano's "symptom complex fits in well with a gradual development of degenerated, herniated C5-6 syndrome."

Kaiser Permanente Hospital
(EX 74)

March 1, 1993 -- Mr. Kitano completes a senior plan health questionnaire. His sole annotated physical concern is "ruptured disc." He rated his physical health as "excellent." One of his providing physicians was Dr. Bhat. He characterized his work activity as "full time."

November 11, 1995 -- In a pre-operation questionnaire, Mr. Kitano indicates that he is bothered by neck and back pain but does not experience joint pain, swelling or arthritis. He also noted that a physician had previously diagnosed arthritis. In the associated medical history of the questionnaire, Dr. Alex Stephen reported that Mr. Kitano had DJD (degenerative joint disease) with associated pain complaints and a decrease in range of motion. The physician annotated that "x-rays of the left middle finger from November 10, 1995, reveals severe distal interphalangeal joint arthritis with osteophyte formation."

April 21, 1999 -- During a treadmill stress test, Mr. Kitano had "fair exercise tolerance."

Dr. Landis W. L. Lum
(EX 74)

February 23, 2000 -- Mr. Kitano presented with left shoulder pain. He reported intermittent left shoulder pain for the past several years. In January 2000, he had a dermatology procedure accomplished on his left shoulder. Dr. Lum found "decreased internal rotation and abduction of the left shoulder with some tenderness of the anterolateral aspect." Dr. Lum diagnosed left shoulder bursitis. He prescribed motrin and swinging exercises for the range of motion problem.

Clinic Report
(EX 23 and EX 74)

June 18, 2000 -- Mr. Kitano presented at the clinic with a knee pain complaint. That morning, Mr. Kitano had stepped on a rock, twisted his right knee and "something snapped." The examination did not find any swelling. However, Mr. Kitano had pain on the medial aspect of his right knee and had difficulty walking. The physician diagnosed right knee sprain and prescribed rest and ice. Mr. Kitano was placed off duty for two days.

Dr. Stein E. Rafto
(EX 24 and EX 74)

June 19, 2000 -- In four x-ray views of Mr. Kitano's right knee, Dr. Stein E. Rafto, a radiologist, observed "mild narrowing of the medial joint compartment and pointing of the tibial spines. . . without prominent degenerative change." The lateral view did not show joint effusion. Likewise, no fracture or foreign body was observed.

Dr. John M. Sandor
(EX 26, EX 45, EX 46, and EX 74)

June 29, 2000 -- Dr. Sandor, board certified in family practice,[12] examined Mr. Kitano concerning his right knee injury. Employed as a part-time golf course attendant, Mr. Kitano had stepped on a rock and twisted his right knee. He did not hear a "pop." Mr. Kitano reported slight swelling that day. He continued to experience discomfort on the medial aspect, "especially when going from sitting to standing position." He also experienced pain when he placed his heel on the ground. Upon examination, Dr. Sandor noted Mr. Kitano tended to walk on his toes. However, he did not have a limp. The knee range of motion was 0 to 160 degrees. He found neither tenderness at the joint line nor ligament instability. On the other hand, Dr. Sandor observed "1+ effusion with warmth" and "mild tenderness on the medial collateral ligament." Dr. Sandor diagnosed medial collateral ligament sprain of the right knee. He prescribed a knee supporter with lateral stays and returned Mr. Kitano to "full duties as tolerated."

July 13, 2000 -- Mr. Kitano reported that he liked the knee splint. He denied any "clicking, popping or locking at the knee." However, he continued to have pain along the medial aspect with some movement. Dr. Sandor noted the absence of effusion and found tenderness over the medial collateral ligament.

August 3, 2000 -- Mr. Kitano reported continued soreness in his right knee without the splint. Mr. Kitano pointed to the patellar tendon as the source of his pain.

August 24, 2000 -- Mr. Kitano did not have joint line tenderness or effusion. Dr. Sandor prescribed continued physical therapy. He diagnosed knee sprain.

[12]As I informed the parties at the hearing (TR, page 6), I take judicial notice of Dr. Sandor's board certification and have attached the certification documentation.

November 16, 2000 -- Mr. Kitano continued to have right knee problems. At times, he experienced very sharp pain. He pointed to the medial tibia region as the source of the pain. Range of motion was slightly limited. Dr. Sandor diagnosed right knee bursitis following a sprain and administered a lidocaine injection. Dr. Sandor also provided a new knee supporter and concluded Mr. Kitano could continue with full duties.

November 30, 2000 – Mr. Kitano reported that the injection provided no relief and his pain remained the same. The source of the pain was difficult to localize. Dr. Sandor diagnosed persistent knee pain following a twist injury. He decided to refer Mr. Kitano to an orthopedic surgeon to rule out a torn meniscus. In his referral of Mr. Kitano to Dr. Van Meter, Dr. Sandor indicated that the right knee x-ray was unremarkable.

October 4, 2001 -- Dr. Sandor reviewed Dr. Van Meter's treatment of Mr. Kitano's right knee. Unfortunately, Mr. Kitano's right knee pain continued. Mr. Kitano reported some discomfort in his left knee due to his limping and the pressure he placed on the left knee. On examination, the right knee showed no focal tenderness. Likewise, the left knee had neither focal tenderness nor effusion. Dr. Sandor diagnosed DJD of the right knee with aggravation secondary to a meniscus tear. Mr. Kitano's left knee pain was "secondary to his altered gait." He determined Mr. Kitano had reached maximum medical improvement with temporary partial disability that was stable and ratable. Dr. Sandor restricted Mr. Kitano from: running, jumping, lifting over 25 pounds, and carrying more than 25 pounds. He also permitted only occasional squatting, kneeling, and climbing.

October 26, 2001 -- Dr. Sandor submitted a report indicating Mr. Kitano's permanent work restrictions.

January 10, 2002 -- Dr. Sandor evaluated Mr. Kitano's right knee. Subjectively, Mr. Kitano indicated his knee still hurt. He also stated that his left knee was hurting. Objectively, Dr. Sandor noted 1+ effusion in the right knee but without warmth. The left knee did not have any effusion. Mr. Kitano hobbled when he walked and could not fully extend his right knee. Dr. Sandor diagnosed right knee post-trauma arthritis. He placed Mr. Kitano on permanent duty restrictions including no running or jumping; limited squatting, kneeling and climbing; standing and walking only as tolerated; and, no lifting greater than 25 pounds.

March 14, 2002 -- No change in Mr. Kitano's condition.

June 13, 2002 -- With a new medication, Mr. Kitano was achieving some relief. He continued to tolerate his part-time work well. Both knees had some slight range of motion loss.

October 25, 2002 Mr. Kitano's right knee still hurts.

Dr. John R. Hannon
(EX 74)

September 21, 2000 -- Mr. Kitano's right knee sprain had improved. He experienced only slight tenderness. His range of motion was normal and pain free.

October 19, 2000 -- Mr. Kitano reported that physical therapy was not helping his right knee. Dr. Hannon found slight tenderness over the medial collateral ligament and full range of motion. Mr. Kitano was "able to make a 3/4 squat and assume an upright position without problem." Dr. Hannon stopped the physical therapy and prescribed exercise, in particular swimming.

Dr. Jerry W. Van Meter
(EX 27, EX 28, EX 30, EX 32, EX 36, EX 40, EX 42, and EX 74)

December 14, 2000 -- Dr. Van Meter, board certified in orthopedic surgery,[13] examined Mr. Kitano's right knee. He described 0 to 130 degrees of flexion and the absence of effusion or swelling. Mr. Kitano demonstrated positive medial joint line tenderness. Although the knee x-rays appeared normal, Dr. Van Meter believed Mr. Kitano may have a medial meniscus tear. Because Mr. Kitano could not be administered an MRI (due to a foreign object in his eye), Dr. Van Meter scheduled an arthrogram.

December 20, 2000 -- An arthrogram revealed the presence of joint effusion and blunting of the mid and posterior horn of the medial meniscus. The diagnosis was "probable tear of medial aspect of the meniscus along the mid portion and posterior horn. "

February 16, 2001 -- Dr. Van Meter performed arthroscopic surgery on Mr. Kitano's right knee. Upon initial observation of the medial joint line, Dr. Van Meter noted a medial meniscus tear in the posterior and middle two-thirds of the medial meniscus. The tear was "complex in nature." Dr. Van Meter excised the tear. Additionally, the medial femoral condoyle and tibial plateau showed "arthritic changes;" in particular, there was a grade IV change and full thickness loss of articular cartilage. Other portions of the knee joint were normal. Upon conclusion of the procedure, Dr. Van Meter diagnosed medial meniscus tear and arthritis.

February 22, 2001 -- Mr. Kitano was experiencing intermittent aching following his surgery. No swelling was noted.

March 13, 2001 -- Mr. Kitano's major complaint was "occasional aching on the medial aspect of his knee when standing up from a sitting position." Dr. Van Meter concluded Mr. Kitano was "doing well except for arthritis of the right knee." He returned Mr. Kitano to work at limited duty at a desk job for two reasons, "meniscus tear" and "DJD" (degenerative joint disease).

April 12, 2001 -- Mr. Kitano's knee function was improving but he required continued physical therapy. He did not have any joint line tenderness.

May 15, 2001 -- Dr. Van Meter examined Mr. Kitano's knee and found no effusion. Mr. Kitano reported continued pain and Dr. Van Meter noted tenderness along the medial joint line. The knee's range of motion was 0 to 130 degrees. The physician repeated that he observed grade IV arthritis on the medial tibial plateau and grade III on the medial femoral condoyle. Dr. Van

[13]I take judicial notice of Dr. Van Meter's board certification and have attached the certification documentation.

Meter treated the knee with an injection. The physician concluded that Mr. Kitano's arthritis was "pre-existing the meniscus injury" and remained the cause or source of his knee pain.

June 21, 2001 -- In a follow-up visit, Mr. Kitano reported continued aching in his right knee. Dr. Van Meter attributed the complaint to arthritis. The doctor diagnosed arthritis pain and recommended continued physical therapy and medication.

July 26, 2001 -- Dr. Van Meter returned Mr. Kitano to full duty effective July 30, 2001. He imposed a weight limit restriction of no more than 30 pounds unless Mr. Kitano was assisted by another person. His diagnosis was meniscus knee and arthritis.

August 30, 2001 -- Dr. Van Meter believed Mr. Kitano's continued pain complaints were related to his pre-existing underlying condition. He was at maximum medical improvement.

September 26, 2001 -- Dr. Van Meter concluded Mr. Kitano had reached maximum medical improvement. No further medical treatment was necessary in regards to the industrial injury. Mr. Kitano's continued pain was "totally related" to "his pre-existing underlying arthritis condition." In regards to the surgical operation on the meniscus, Mr. Kitano was "stable."

Dr. Jon H. Scarpino
(EX 47 and EX 74)

February 14, 2002 -- Dr. Scarpino conducted a follow-up examination. Mr. Kitano had no change in his knee pain. He was having some gastric problems associated with the prescribed medication. He worked three days a week for a weekly total of 21 hours. Mr. Kitano was wearing a knee brace. He could only squat halfway due to right knee pain. His medial joint line was tender. While the right leg was less strong than the left leg, both extremities were within normal range. Dr. Scarpino found no evidence of effusion. The range of motion was good. Dr. Scarpino diagnosed "torn meniscus right knee, status post arthroscopic intervention to arthritic change right knee." Mr. Kitano had reached maximum medical improvement from his surgery. His symptom would most likely continue and medication for his long-term knee problem was necessary and additional future surgery was possible.

October 25, 2002 -- Dr. Scarpino again evaluated Mr. Kitano's right knee who still complained about knee pain and had been placed off work by Dr. Hager. Mr. Kitano was also claiming arthritis in both shoulders and his left knee. Dr. Scarpino believed Mr. Kitano's gait was normal but he had an antalgic[14] limp. He could not squat very well and was unable to reach the last few degrees of extension. His ligaments were stable. Dr. Scarpino agreed with Dr. Van Meter that Mr. Kitano's remaining symptoms were related to "the underlying osteoarthritis and not caused by the work injury of 06/18/2000." His diagnosis was "osteoarthritis right knee."

[14]A gait assumed so as to lessen pain. DORLAND'S ILLUSTRATED MEDICAL DICTIONAY 90 (28th ed. 1994).

Dr. Gilbert P. Hager

Medical Treatment Record – May 2002 to March 2003
(CX 2, CX 5, EX 50, EX 52, and EX 55)

May 14, 2002 -- Mr. Kitano presented to Dr. Hager with bilateral shoulder and knee pain. Mr. Kitano indicated that his problems began in 1990 with a work-related injury due to carrying drywall and painting. Since then, he has noticed "gradually increasing bilateral shoulder pain." Dr. Hager indicated that Mr. Kitano's "*left* shoulder was rated 22% disability" (emphasis added) due to range of motion limitations. In about 2001, Mr. Kitano suffered another work-related injury when he twisted his right knee. That injury lead to knee surgery. Since the operation, his right knee has not improved. Additionally, he has developed left knee pain because of shifting his weight away from the right knee. He characterized his pain as a burning sensation. The highest levels of pain were in his left shoulder and right knee. At present, Mr. Kitano was working 22 and a half hours at a golf course performing cart maintenance. His gait was antalgic.

During the examination, Dr. Hager reported Mr. Kitano's right shoulder was tender over the supraspinatus tendon and had some limited range in motion due to pain. The left shoulder was tender over the same tendon with more extensive limited range of motion. Although Mr. Kitano's right knee was diffusely tender, it retained full range of motion and normal strength and tone. The left knee was tender at the medial joint line "with effusion." Full active range of motion was possible with pain. Dr. Hager diagnosed bilateral shoulder and knee derangement. He recommended CT scans for the shoulders and knees and referred Mr. Kitano for consideration of surgical options.

June 12, 2002 -- During this follow-up visit, Mr. Kitano's symptoms and examination results remained essentially unchanged. The recent CT scan of the right knee showed small effusion at the suprapatellar joint, spurring, and moderate degenerative changes of the medial compartment. The shoulder CT scan showed "osteoarthritis of the upper thoracic spine only." Mr. Kitano was scheduled to return after the orthopedic referral.

July 26, 2002 -- Dr. Hager placed Mr. Kitano in off-duty status for four weeks.

August 23, 2002 -- Dr. Hager renewed Mr. Kitano's off-duty status, effective that date until January 2, 2003.

January 17, 2003 and February 14, 2003 -- On these two days, Dr. Hager examined Mr. Kitano and annotated similar findings. Mr. Kitano is a 74 year old man with complaints of bilateral shoulder and knee pain. He had been working as a golf course cart maintenance person a little over 22 hours a week. His problems started about 12 years earlier when he suffered a work-related injury moving drywall and painting. About 10 years earlier, his "left" shoulder was rated 22% disability for loss of motion. Then, about a year before the first examination by Dr. Hager, Mr. Kitano twisted his right knee at work and eventually had knee surgery. Ten months of physical therapy have not improved his knee condition. Dr. Okamura believes Mr. Kitano has a shoulder derangement. Mr. Kitano reports his pain levels as follows: right knee – 9, left knee – 6, right shoulder – 6; and, left shoulder 9. The pain is a burning sensation.

Mr. Kitano reports no change in either quality or location of his symptoms. His gait was antalgic with a short stance on the right. The range of motion of his lumbar spine was limited to 60 degrees by pain. His right upper extremity was tender to touch and limited in range of motion to 170 degrees by pain. His left upper extremity was also tender and restricted to 85 degrees by pain. The right knee was arthritic with diffuse tenderness. Dr. Hager found full range of motion and stability. The left knee's tenderness was located at the medial joint line with effusion. Full range of motion, with pain, and stability were present.

Dr. Hager's diagnosis continued to be bilateral shoulder derangement with "post-traumatic osteoarthritis; post-traumatic osteoarthritis in both knees," and torn medical meniscus in the left knee. He intended to have an x-ray arthrogram of the shoulders and knees accomplished.

March 14, 2003 -- During this examination, Mr. Kitano reported some changes in his pain levels. In his right knee, he was experiencing pain at the 6-7 level; his left knee was 3-4. In his right shoulder the pain level was 4-5; the level in the left shoulder was higher at 6-7. Dr. Hager scheduled Mr. Kitano for another orthopedic evaluation.

Deposition – April 2003
(EX 83)

Dr. Hager's work consists of 90% clinical practice. About half of those patients involve worker compensation injuries. In Dr. Hager's opinion, insurance companies are "less interested in the truth than in an opinion that would support their ability to limit or discontinue payment for the case." In trying to evaluate a person's condition, Dr. Hager attempts to determine the mechanism of the injury. If he determines an injury is work-related, he advises the patient to file a worker's compensation claim. At the same time, if the injury is not work-related, then he will advise the patient that they can't charge the worker's compensation carrier.

He first saw Mr. Kitano on May 14, 2002 within the context of a worker's compensation claim. Mr. Kitano's attorney had asked him to see Dr. Hager. Dr. Hager had not reviewed Mr. Kitano's medical records. Instead, he has relied on Mr. Kitano's recollection of his medical history. At their first meeting, Mr. Kitano did not recall precise dates; he was not the best historian.

Mr. Kitano had complaints of bilateral shoulder and knee pain. He indicated his problem started twelve years earlier when he suffered an injury while working construction, carrying drywall and painting. Due to the injury, he received a 22% disability rating about ten years ago. Additionally, about a year before seeing Dr. Hager, Mr. Kitano had twisted his right knee at work; that injury eventually led to surgery. Subsequently, he developed left knee pain due to shifting his weight away from the right knee. After ten months of physical therapy, he had no improvement in the condition of his right knee. Dr. Hager did not question Mr. Kitano about his reference to osteoarthritis in his right knee.

In assessing Mr. Kitano's pain levels, Dr. Hager used a range of zero for no pain to ten for extremely severe pain. The pain level of eight for Mr. Kitano's right knee means very severe

pain which requires a person to stay in bed most of the time and to use pain medication. At the time of the examination, Mr. Kitano was only taking aspirin and medication for cholesterol which has a mild pain medication component. His pain level of five for his left knee and right shoulder equates to discomfort that is not relieved by aspirin. His nine level for the left shoulder is extremely severe pain that is almost unbearable. Mr. Kitano characterized all four pain levels as burning. At the time of the first examination, Mr. Kitano was still working at the golf course on modified duty, 22 and a half hours a week. His primary work involved cart maintenance. At the time of the deposition, Dr. Hager had no additional information on Mr. Kitano's work regarding cart maintenance.

On physical examination, Dr. Hager noted that Mr. Kitano's gait reflected some pain. The cervical, thoracic, and lumbosacral portions of his spine were normal in terms of tenderness and pain. Mr. Kitano was tender over the supraspinatus tendon, which is located at the top of the shoulder blade. His right shoulder had a "fairly mild range of motion loss." His muscle strength and tone were limited by pain. The painful tendon would account for these findings. Dr. Hager found the same symptoms in the left shoulder; the loss of range of motion was greater.

Mr. Kitano was wearing a brace on his right knee. During the examination, Dr. Hager moved the knee in all planes. He didn't note the presence of swelling and the knee had full active range of motion. The knee joint was stable. The musculature was normal. Similarly, the left knee and its musculature looked normal. However, the joint line was tender with palpable effusion. The active range of motion was full.

Dr. Hager diagnosed bilateral shoulder and knee derangement because something was causing Mr. Kitano's pain and range of motion limitations, but he could not specifically identify the cause. Although he didn't include Mr. Kitano's history of right knee osteoarthritis in his report, Dr. Hager acknowledged that he should have included that comment. Dr. Hager recommended a CT scan of the shoulders and knees. The subsequent CT scan of the right knee showed diffusion, spurring and moderate degenerative arthritic changes in the right knee. This study helped Dr. Hager refine his diagnosis for the right knee. The arthritic changes were osteoarthritis. Consequently, he changed his diagnosis to post-traumatic osteoarthritis of both knees; his diagnosis concerning the left knee is an assumption. Although Dr. Hager also diagnosed post-traumatic osteoarthritis in both shoulders, that assessment is incorrect. The shoulder CT scan only indicated the presence of degenerative changes in the upper thoracic spine. Since the radiographic study did not contain a finding in regards to the shoulders, he must have misread the CT scan report in making his diagnosis. Dr. Hager no longer believes Mr. Kitano has post-traumatic osteoarthritis in both shoulders.

Dr. Hager referred Mr. Kitano to Dr. Okamura for evaluation of his knees and shoulders. Dr. Okamura diagnosed tendonitis and possible rotator cuff tear in both shoulders. But without an MRI or arthroscopic evaluation, the tear can't be confirmed. Dr. Okamura believed both knees were arthritic and the left knee might also have a meniscus tear, which was consistent with the medial joint line tenderness. The arthritic conditions would explain Mr. Kitano's symptoms with the exception of the medial joint tenderness.

Since the initial examination, Dr. Hager has seen Mr. Kitano seven times. Through the visits in June and July, Mr. Kitano was still working at the golf course. On July 26th, because Mr. Kitano's pain levels in his left knee and shoulder were increasing and he hadn't been able to determine the cause of the increase, Dr. Hager recommended that Mr. Kitano stop working in cart maintenance. Dr. Hager wanted to make sure Mr. Kitano was not at risk. At that point, Dr. Hager would have precluded any squatting, kneeling, or overhead work. After reviewing Mr. Kitano's job description, Dr. Hager does not believe Mr. Kitano is capable of handling the duties. He was particularly concerned about the weight lifting requirement and the "very awkward ergonomic" work. Although he is not totally physically disabled from any work, Mr. Kitano has significant limitations.

Since the anti-inflammatory medication did not appear to help Mr. Kitano, Dr. Hager no longer prescribed medication by the time of the last visit in March 2003. As of the last visit, the pain levels had decreased. Dr. Hager believed that change occurred because Mr. Kitano was no longer working. In Dr. Hager's opinion, Mr. Kitano's "workability is very limited" since all four limbs are "involved with joint pain and derangement."

In Dr. Hager's opinion, the "current degree of discomfort and pathology" of Mr. Kitano's problems "is related to his activities at work." Specifically, with arthritic knees, Mr. Kitano was "on his feet all day long, washing carts, dragging hoses."

Hearing Testimony – May 2003
(TR, pages 41 to 114)

[Direct examination] Dr. Hager, who is board certified in physical medicine and rehabilitation,[15] spends about 90% of his practice treating patients. Of those patients, about 20% have knee problems; another 20% of the patients have shoulder issues. He has seen Mr. Kitano nine times. In his medical history, Mr. Kitano reported a shoulder injury in 1990 and a right knee injury in 2000. Dr. Hager has also reviewed the medical records from Kaiser hospital.

Upon his initial examination of Mr. Kitano in May 2002, Dr. Hager observed tenderness in particular areas of his shoulders and limited range of motion. He suspected an internal derangement due to tendonitis. Although Mr. Kitano was unable to undergo an MRI, Dr. Hager did obtain a CAT scan of his shoulders. The CAT scan was inconclusive. His diagnosis is bilateral shoulder derangement. He also suspects the presence of some arthritis. Though neither x-rays nor the CAT scan established its presence, Mr. Kitano's symptoms are indicative of arthritis, or inflammation of the shoulder joint. There's no spurring.

Dr. Hager also referred Mr. Kitano to Dr. Okamura, an orthopedic surgeon who specializes in shoulders. Dr. Okamura agrees Mr. Kitano has derangement in both shoulders.

Dr. Hager evaluated Mr. Kitano's knees and also found derangement. He suspected meniscal tears in both knees. Upon examination of the medical record, Dr. Hager noted that when conservative treatment did not help Mr. Kitano's right knee after the 2000 injury, a

[15]Based on the parties' stipulation, I accepted Dr. Hager as an expert in physical medicine and rehabilitation (TR, page 42).

detailed x-ray in January 2001 (EX 28) showed some tearing of the medial meniscus on the right side. As a result, the physician performed arthroscopic surgery on the right knee. While Dr. Hager did not observe any photos from the procedure, the physician indicated he accomplished an effective meniscus repair. However, Mr. Kitano's right knee did not return to normal. After taking some time off, Mr. Kitano returned to work in order to make money. Dr. Hager examined Mr. Kitano's right knee two years after the surgery. At that time, Mr. Kitano had very severe pain in the right knee, particularly in the area of the right meniscus and the medial meniscus on the right side. Diffuse tenderness existed around the knee. Recent x-rays of the knee show arthritis. Dr. Hager recommends a diagnostic test to determine whether further surgery would help the problem.

When Dr. Hager examined the left knee, Mr. Kitano complained about pain. The pain in the left knee was worst than the right knee. Upon examination of the left knee, the physician found diffuse tenderness around the knee and tenderness along the medial joint line. Mr. Kitano reported that in the course of his employment, his knees would be painful when he got home. Over time, they seemed to be getting worse. According to Dr. Hager, Mr. Kitano has arthritis in both knees. In the report of the earlier right knee surgery, Dr. Hager doesn't remember any reference to arthritis.

Upon his review of the medical record, Dr. Hager didn't recall seeing any problems with Mr. Kitano's right knee. Mr. Kitano also reported that he had not experienced any problems before the June 2000 accident. In June 2000, when he stood up from kneeling or leaning down, Mr. Kitano stepped on a rock with his right foot and twisted his knee. The treating physician released Mr. Kitano to work with permanent lifting and kneeling restrictions and an impairment. According to Mr. Kitano, he was not able to comply with the restrictions at work.

When Mr. Kitano presented with his pain complaints in both knees, he only described the accident involving the right knee in 2000. However, Dr. Hager believes the left knee problem is related to the right knee's condition. Due to the right knee injury, Mr. Kitano has a "gnathalgia gait." In response to his right knee pain, he has changed the way he does things and put more load on the left knee. He shortened his "stance phase, which means he gets off the right side faster." If asked to accomplish a leg bending task, Mr. Kitano will bend the left knee in deference to the pain in the right knee, placing more load on the left knee. Mr. Kitano has favored his right knee for some time. Dr. Hager acknowledged that "at this point in time he gets off both [knees] pretty quickly, as his gait is difficult to evaluate because he has a bilateral gnathalgia."

Based on Mr. Kitano's statements in 2002, Dr. Hager believes Mr. Kitano's condition worsened when he returned to work after the 2000 accident. However, Dr. Hager did not have "objective evidence." He was still attempting to evaluate Mr. Kitano's condition.

Dr. Hager does not believe Mr. Kitano's right knee has reached MMI "because I don't think he's been fully evaluated." For the same reasons, the left knee is not at MMI. Dr. Okamura is waiting to proceed with arthrograms to see if anything is repairable in the knees.

According to Dr. Hager's understanding of the 1990 injury to the right shoulder, Mr. Kitano suffered an overuse injury carrying drywall. Following the injury, Mr. Kitano received conservative treatment in the form of physical therapy. He then returned to work with some work restrictions; Dr. Hager doesn't recall the specific restrictions. Based on his 2002 examination, Dr. Hager believes Mr. Kitano's right shoulder has "gotten worse over the time since he was released to work from his 1990 injury." He believes Mr. Kitano is suffering a cumulative injury because:

> increasing pain is related generally to increasing pathology of some kind, either just swelling from tendonitis – it could be that; it could be impingement. But if there was a derangement in that shoulder that's never been -- where it had never been appropriately evaluated, that would be getting worse over time and possibly creating an arthritis component with respect to inflammation if not with arthritic spurring.

Dr. Hager explained that a cumulative injury occurs when repetitive use of a body part in strenuous activities, other than daily living activities, tax the joints. Additionally, a pre-existing injury "predisposes . . . [a] person to a worsening condition and that's the definition of a cumulative injury, aggravation."

In Mr. Kitano's case, his work at the golf course requires him to lift heavy buckets of golf balls up to shoulder level to place them in a washer. He also accomplishes other heavy labor, such as changing golf cart tires. That work violates his work restrictions for both his shoulders and knees. When he's charging 100 golf cars, Mr. Kitano is repetitively pulling out electric cords and plugging them in. He also must pull hoses around to wash the carts. Mr. Kitano should not be doing these tasks which require kneeling and reaching above his shoulders. Even though he is just working part-time, 20 hours a week, these repetitive activities "are bad for him."

A 1997 NIOSH study linked certain activities with certain injuries. Based on that study, Dr. Hager believes Mr. Kitano's lifting weight up to shoulder-level is a problem.

In a manner similar to Mr. Kitano's knee situation, he also has favored his right shoulder, thereby placing additional stress on his left shoulder. As a result, Mr. Kitano has a left shoulder problem of an industrial nature. His left shoulder problem will worsen as it takes "up the slack for the right shoulder." If the left shoulder had pre-existing arthritic changes, then the joint is more predisposed to cumulative injury.

Based on his physical examination of Mr. Kitano, his work history, and a consulting shoulder specialist's observation about arthritic changes, Dr. Hager believes Mr. Kitano suffered a bilateral cumulative shoulder injury between 1994 and 2002. Dr. Hager does not believe Mr. Kitano had a pre-existing shoulder joint problem; he was working fine until his right shoulder injury.

When Dr. Hager first saw Mr. Kitano, he was not his treating physician under the workers' compensation program. However, when Mr. Kitano returned in July 2002 and told him

that he was still working despite his physical problems, Dr. Hager asked him what his treating physician was doing about the situation. When Mr. Kitano replied "nothing," Dr. Hager told him that he can't work anymore. According to Dr. Hager, Mr. Kitano was "in misery with pain at eight, nine, ten levels, getting worse everyday he went to work." So, Dr. Hager took him off work on July 26th due to both his knee and shoulder problems. Even if Mr. Kitano did not have knee problems, Dr. Hager would still have removed him from work, and vice versa. Mr. Kitano will be able to return to appropriate work only if more diagnostic tests are made and his problems are fixed.

According to the Fifth Edition of the AMA Impairment Guide, an impairment does not directly translate into a disability. Concerning Mr. Kitano's right knee, he has a ratable impairment due to the arthritis, gait problem, and mild loss of cartilage. In other words, Mr. Kitano has a ratable right knee impairment because of his limp and use of a brace. Without looking at that guide, he was unable to give a specific number. Disability relates to the ability to compete in the labor market. Mr. Kitano's impairments would increase his difficulty in the labor market.

[Cross-examination] Dr. Hager generally refuses to do IMEs for insurance carriers. When he first saw Mr. Kitano upon referral from Mr. Birnbaum, Mr. Kitano had a treating physician for his knees. At that time, he didn't have Mr. Kitano's medical records. Since then, he has reviewed some of the records from Kaiser. However, he has not seen the medical reports regarding the 1990 injury. He has only seen records from 2000 regarding the knee and subsequent injuries. Dr. Hager has reviewed Dr. Van Meter's treatment notes and recalled the entry that Mr. Kitano had reached MMI from the knee surgery and his condition was totally related to pre-existing underlying arthritis condition. However, Dr. Hager disagrees with that assessment because he saw no evidence of a pre-existing arthritic condition. Dr. Hager acknowledged that the surgical report "mentions some arthritis." He also observed the entry, "DJD" which means degenerative joint disease and is another method of describing pre-existing arthritis. Nevertheless, Dr. Hager noted that he had not seen any evidence of DJD or arthritis on any other evaluation. That is, the first mention of arthritis was the arthroscopic evaluation in February 2001. Both an earlier x-ray and an arthrogram were normal. The arthroscopic surgery occurred eight months after the accident, which is sufficient time for arthritis to develop. Consequently, Dr. Hager disagrees with the assessment that Mr. Kitano's knee had returned to its pre-existing condition. According to Dr. Hager, Mr. Kitano's "totally underlying arthritis condition is a result of meniscal tear, he had no arthritis showing up on x-rays or arthrogram prior to the date of arthroscopic repair." Finally, Dr. Hager concurred with Dr. Van Meter's conclusion that no further treatment was necessary in regards to the surgical procedure.

Dr. Hager has no reason to doubt the medical entry from November 1990 indicating Mr. Kitano felt improved after physical therapy. Dr. Hager has requested testing from Kaiser but they have declined, claiming it's a workers' compensation case.

Dr. Hager's assessment of Mr. Kitano's ability to return work is based entirely on the work history he presented. He doesn't independently know whether Mr. Kitano suffered a right shoulder or neck injury in 1990. Based on Mr. Kitano's history, including his report of a 22 percent disability rating for loss of motion, Dr. Hager believes it was a shoulder injury.

Mr. Kitano reported a pain level of eight which would force most people to stay in bed. He doesn't take medication. At the day of the hearing, Dr. Hager believed Mr. Kitano may be subjectively experiencing level eight pain. He has significant pain in all affected areas. Dr. Hager believes his pain complaints and his "physical examination was consistent with pathology." An orthopedic specialist also agrees that Mr. Kitano has derangements in his shoulders and knees. The pathology evidence includes the clinical examination and evidence of bilateral meniscus tears and possible derangement in both shoulders with tendonitis and arthritis. The later conditions do not show very well on an MRI.

Concerning the clinical examination, Mr. Kitano had point tenderness over the labrum of the shoulder with subjective pain. He did not observe any inflammation or edema; but inflammation of the joint is not externally observable. He did not find any instability in either the shoulders or knees. Both the right and left knee joints are stable. Likewise, the shoulders are stable.

Dr. Hager reviewed the surveillance film. The wooden frame appeared to have concrete footings. It probably weighed about 25 pounds, which is within his lifting restriction for his knees. In his job, Mr. Kitano was required to lift, with the help of another man, a 45 pound bucket of golf balls into a ball washing machine. The repetitive nature and height of the lifting concerns Dr. Hager. He doesn't recall the specific frequency of the ball washing task. Mr. Kitano is capable of doing more than he should.

Again, Mr. Kitano could have a ratable impairment but still not be disabled. Mr. Kitano is temporarily totally disabled due to pain in both shoulders and knees with activity. His present condition is temporary "at least until we can get the diagnostic tests we need and find out what can be repaired."

[Re-direct examination] Confusion between a cervical spine and shoulder injury is very common because pain radiates from the shoulder to the neck and from the neck to the shoulder. On page 453 of the medical records, the entry indicates right shoulder, arm pain with a precaution for cervical radiculopathy. Page 448 also references tenderness in the right shoulder with no change in range of motion. These reports are consistent with Mr. Kitano's history of right shoulder problems in 1990 and 1991.

[Re-cross examination] The records reviewed above also report the physician's impression of cervical radiculopathy with degenerative C-spine (cervical spine) at C5-6. There's no indication the doctor believed the problem was related to the shoulder. Dr. Hager has no basis to disagree with the 1990 report.

Dr. Richard L. DeJournett
(EX 51)

May 23, 2002 -- Dr. DeJournett interpreted CT scans of Mr. Kitano's shoulders and neck. He found no calcification in the shoulder joints. Degenerative changes were observed in the visualized upper thoracic spine. The physician also evaluated a CT scan of the right knee. He noted spurring at the superior insertion of the patellofemoral ligament and tibial spines. He saw

small right side effusion. The medial compartment joint space was narrowing and subchondrial sclerosis was present. Dr. DeJournett diagnosed small effusion, spurring, and "moderate degenerative changes involving the medial compartment and about the intercondytar notch."

Dr. Gary Y. Okamura

Medical Treatment Records – July 2002 to April 2003
(CX 2, CX 5, and EX 54)

July 11, 2002 -- Based on a referral from Dr. Hager, Dr. Okamura, board certified in orthopedic surgery, evaluated Mr. Kitano's complaints of bilateral shoulder and knee pain. According to Mr. Kitano, he hurt both shoulders in 1990 when he had to do a lot of sanding and painting. He claimed to have received a 20% impairment rating for his shoulders. He has difficulty using his arm due to the shoulder pain. A CT scan was negative for the shoulders but showed degenerative changes in the upper thoracic spine.

Mr. Kitano's knee pain was greater on the left than the right. He claimed that the right knee problem was covered by worker's compensation. Since surgery on his right knee, Mr. Kitano had been favoring it and putting more pressure on the left to the extent it developed pain. A CT scan of the right knee revealed spurring and moderate degenerative changes in the medial compartment. He has not experienced swelling in his knees. He presently was working part-time as a golf course attendant.

On examination, Dr. Okamura observed that Mr. Kitano had limited range of neck motion due to pain. He had some tenderness over the acromioclavicular and sternoclavicular joints. The left shoulder appeared more tender than the right shoulder. Shoulder range of motion was limited by pain. Mr. Kitano had "slight weakness involving his rotator cuff tendon." The knees' range of motion was also diminished due to pain. Mr. Kitano had tenderness bilaterally along the medial compartment. The three x-ray views of the shoulders indicated "some degenerative arthritis involving the AC joint, less so on the left." In the knee x-rays, Dr. Okamura found "some medial joint space narrowing." No significant spurs or osteophytes were noted.

Dr. Okamura diagnosed a) bilateral shoulder tendonitis, with a possible rotator cuff tear; b) left shoulder superior labral tear; c) bilateral knee arthritis; and d) possible left knee meniscus tear. He recommended arthrograms for the left knee and the possible meniscus tear, and both shoulders for the rotator cuff tears.

April 25, 2003 -- Dr. Okamura conducted a follow-up examination of Mr. Kitano's orthopedic condition. Mr. Kitano reported no improvement in his shoulder pain. His right knee is troubling him more than the left knee. About two weeks earlier, he was unable to walk due to the pain. He wears a brace on the right knee. As he takes more weight on the left knee, it starts to bother him.

Upon physical examination, Dr. Okamura found limited range of motion in the shoulders consistent with impingement. Neither knee showed evidence of effusion. Dr. Okamura

diagnosed: bilateral shoulder tendonitis, possible left rotator cuff tear, bilateral knee arthritis and possible left knee meniscal tear. After Dr. Okamura administered an injection of Xylocaine in both shoulders, Mr. Kitano's strength improved and the impingement symptoms were "less positive."

Dr. Okamura noted his disagreement with Dr. Smith's interpretation of the outlet view of the shoulders. According to Dr. Okamura, the outlet view showed a normal, not curved or hooked, acromion.

Deposition – July 2003
(CX 7)

In his practice, Dr. Okamura specializes in shoulder problems. He performs operations several times a week. He first saw Mr. Kitano on July 11, 2002 based on a referral from Dr. Hager. Mr. Kitano presented with complaints of bilateral shoulder and knee pain. His left shoulder pain was greater than the sensation in the right shoulder. A CT scan of the shoulder was negative for bony abnormalities. Upon physical examination, Dr. Okamura noted Mr. Kitano had tenderness in the acromioclavicular joint and the sternoclavicular joint. The left shoulder was more tender. Mr. Kitano experienced stiffness in both shoulders. Impingement signs were positive bilaterally. He had weakness involving the rotator cuff tendons. At that time, Dr. Okamura's diagnosed bilateral shoulder tendonitis, with possible bilateral rotator cuff tear and a superior labral tear in the left shoulder.

Concerning the etiology of the shoulder problems, Mr. Kitano indicated that in 1990 he injured both shoulders by doing a lot of sandpapering and painting on the job. Based on Mr. Kitano's statements, Dr. Okamura believes the cause of the shoulder problems were his injuries in 1990. At the same time, other than Mr. Kitano's statements, Dr. Okamura did not look carefully at the medical record to see if there was any other cause. Dr. Okamura recommends an arthrogram of both shoulders.

Mr. Kitano reported that he suffered a work-related right knee injury and underwent knee surgery. Since then, he has been favoring his right knee and putting more pressure on the left knee. Patients often favor the painful side of the body by putting excess stress on the other side. A CT scan of the right knee indicated that he had "longstanding" spurring at the insertion of the patellofemoral joint and moderate degenerative changes in the medial compartment. A 2002 x-ray of the left knee showed some medial space narrowing, but no significant spurs or osteophytes, which represent arthritic changes in the left knee. That pre-existing condition would make it more likely that the left knee would become symptomatic. Dr. Okamura diagnosed bilateral knee arthritis. Additionally, because Mr. Kitano had pain responses in the bilateral medial compartments, Dr. Okamura diagnosed a possible meniscal tear in the left knee. He recommends an arthrogram to further evaluate the possible tear. Dr. Okamura agrees with the statement that absent the right knee problems, and the post-operative increased stress, Mr. Kitano's left knee symptoms would not have appeared or presented as quickly as they did.

Based on his understanding of Mr. Kitano's work at the golf course, Dr. Okamura believes several of the activities, including lifting and overhead movement, would have increased

the pain in, or caused an injury to, his shoulders. Due to the stress on the shoulder, the overhead reaching position would cause more pain and aggravate the underlying shoulder arthritis and tendonitis. Such reaching would also adversely affect any possible tears in the shoulder. Based on Mr. Kitano's job description, Dr. Okamura would expect him to have shoulder problems "over a period of time." He believes Mr. Kitano suffered a cumulative trauma to his shoulders over a period of time. According to Dr. Okamura, the symptoms of arthritis can be increased depending upon a person's work activities.

Following his right knee surgery, Mr. Kitano's complaints of worsening pain would be due in part to the cumulative trauma of those activities. "All those activities of lifting, carrying will put increased stress on his knees." The surgery did not completely resolve his knee problems. The procedure only helped the meniscus tear. The underlying arthritis was not treated by the operation. Mr. Kitano's left knee condition involves a combination of the suspected meniscus tear and arthritis.

In April 2003, Dr. Okamura treated Mr. Kitano's shoulders with cortisone injections. He experienced some improvement in both shoulders. On May 8, 2003, Mr. Kitano reported that both shoulders were feeling much better. He was able to trim hedges and swim. However, Mr. Kitano was not at MMI in regards to his shoulders. He is temporarily totally disabled until he gets additional treatment. Likewise, his knees are not at MMI. He is temporarily totally disabled due to his knees. He needs additional diagnostic tests. If Mr. Kitano returned to work, Dr. Okamura would impose significant work restrictions due to his shoulders in the areas of lifting, pulling, pushing, and reaching. Work restrictions associated with his knees would include squatting and jumping. Climbing one flight of stairs and carrying light loads waist high should not be a problem.

Dr. Okamura has only reviewed the portions of the medical records that have been provided by Mr. Birnbaum. He has not reviewed the opinion of the Kaiser physicians about Mr. Kitano's knees. He did see Dr. Smith's report. He also did not review the surveillance tape.

At the time of the first examination, Mr. Kitano was working part-time. Dr. Okamura "thought he could continue at that time." His assessment on the impact of Mr. Kitano's work activities was based on the assumption that it occurred day in and day out on a five days a week basis.

Dr. Okamura agrees that an attending physician is in a better position to assess the extent and etiology of a condition. Dr. Okamura disagrees with Dr. Van Meter's MMI assessment about the right knee because Mr. Kitano was not offered other treatments available for his arthritis. Dr. Okamura doesn't know whether Mr. Kitano has "totally pre-existing underlying arthritis." Dr. Okamura acknowledged that absent a medical record review his opinion may not be justified.

Dr. Okamura believes Mr. Kitano has arthritic changes in his shoulders. The rotator cuff condition is a "working diagnosis." He thinks there is a possibility of a rotator cuff tear. He remains suspicious about a rotator cuff tear because after the injections, Mr. Kitano still had persistent weakness. Arthritis does not cause such weakness. Although arthritis causes pain and

pain may lead to weakness, Mr. Kitano displayed the weakness even after he obtained pain relief from the injections.

Dr. Robert L. Smith

Medical Record Review – January 2003
(EX 65 to EX 67)

In January 2003, Dr. Robert L. Smith reviewed the August 2002 surveillance videotapes and conducted an extensive medical record review.

Dr. Smith also reviewed the treatment and operation notes from the following physicians: Dr. Bender, Dr. Bhat, Dr. Pang, Dr. Sandor, Dr. Van Meter, Dr. Ma, Dr. Scarpino, Dr. Hager, and Dr. Okamura. He also reviewed the cervical, shoulder and knee x-rays and CT scans from 1990, 2000, 2001, and 2002. Based on this extensive review and summarization, Dr. Smith reached several conclusions concerning Mr. Kitano's various claims.

In regards to the 1990 right shoulder pain complaint, Dr. Smith noted the absence of any direct injury to the right shoulder. Mr. Kitano stated that overuse was the cause of his problems. However, even though the electromyographic examination did not find radiculopathy, the objective medical evidence that helps explain his symptoms is the November 1990 cervical x-ray showing disk narrowing at C5-6 with "uncinate bony spurring impinging upon the right C5-6 neural foramen." In light of Mr. Kitano's age at the time of the study, Dr. Smith opined that the disk degeneration and bony spurring were not abnormal. Consequently, based on this evidence, Dr. Smith did not find a work-related musculoskeletal disorder. Instead, Mr. Kitano's disk degeneration and spurring were pre-existing conditions. He believed Mr. Kitano's claim of injury was speculative. In the absence of any independent or objective evidence of trauma, Dr. Smith stated Mr. Kitano's pre-existing disk problem was not aggravated, accelerated or exacerbated by his work in September 1990. Because Mr. Kitano had near normal range of motion by December 1991, Dr. Smith agreed that Mr. Kitano had reached MMI by that time. He added, "the natural history of degenerative disc disease is one of intermittent exacerbations and remissions, often gradually worsening as the patient ages." Finally, Dr. Smith did not concur with Dr. Ma's 14% impairment rating. Dr. Ma based 10% of the rating for range of motion; yet the neck range of motion was normal and the electromyographic test indicated radiculopathy was not present. Since the condition was essentially age-related, Dr. Smith would apply an impairment rating of 0%.

Turning to the claim of a right knee injury in June 2000, Dr. Smith concluded the etiology of Mr. Kitano's right knee condition was pre-existing osteoarthritis in the medial compartment. Mr. Kitano's work did not aggravate that condition. Based on the arthroscopic report, Dr. Smith also indicated that the meniscus tear was not due to a trauma incident. He believed the operative report showed "a confluence of arthritis and degenerative medial meniscus tear in the posterior horn." In other words, the meniscus tear was degenerative in nature. Mr. Kitano's right knee reached MMI by October 4, 2001 and any remaining symptoms were attributable to his pre-existing arthritic condition. Although a meniscus tear and arthritic knee

have specific impairment ratings, Dr. Smith attributes none of Mr. Kitano's knee problems to work; as result, he would give a 0% rating for work-related injuries.

Mr. Kitano's October 2001 claim of a work-related left knee condition actually involves gradually worsening osteoarthritis and degenerative joint disease. This condition was pre-existing as of Mr. Kitano's October 2001 claim of injury. In the absence of "concrete" evidence of any physical risk exposure for the claimed musculoskeletal disorder, Mr. Kitano's claim that his condition is related to work is speculative. Likewise, Mr. Kitano's work did not aggravate his left knee condition. Additionally, because Mr. Kitano's osteoarthritis and degenerative joint disease are genetic and age-related, it pre-dated any purported change in his gait due to his right knee condition. Any causal relationship is "dubious." His left knee condition has reached MMI. Although he did not disagree with Dr. Okamura's recommendation for a diagnostic arthrogram of the left knee, Dr. Smith noted such a procedure was not related to a work-related injury. He also noted that the right knee arthrogram and corresponding medical intervention did not cure Mr. Kitano's right knee pain. Again, Mr. Kitano's condition is not work-related, the appropriate impairment rating is 0% in regards to any October 2001 injury.

Highlighting the absence of any shoulder abnormalities in the May 2002 CT shoulder scan and x-ray findings in July 2002, Dr. Smith concluded Mr. Kitano's bilateral shoulder pain complaints relate to "pre-existing degenerative arthritis involving the acromioclavicular joints with secondary chronic impingement syndrome." Mr. Kitano's complaint of gradually worsening bilateral shoulder pain is consistent with his degenerative joint disease and is not work-related. He found no evidence of a rotator cuff tear and does not recommend any additional shoulder procedures. Mr. Kitano's degenerative joint disease in both shoulders is medically stable but will nevertheless worsen as he ages. The appropriate work-related impairment rating is 0%.

Since surveillance video indicates an "evaporation of symptoms," Dr. Smith does not believe Mr. Kitano is disabled. However, he recommends a functional capacity evaluation prior to Mr. Kitano's return to work.

Medical Examination – March 25, 2003
(EX 72)

Upon presentation, Mr. Kitano's "subjective" complaints consisted of pain in both shoulders, mainly the left shoulder, and knee pain, mainly the right knee. For the last five months, he has been on leave by Dr. Hager's order. He desired surgery for his left shoulder. Mr. Kitano described his work history. In 1990, he was routinely given tasks usually assigned to three people. He believes his supervisors used the assignments as retaliation for his union steward activities. The overhead work and heavy lifting caused him to overuse his shoulders and he "developed unbearable pain in both shoulders." He continued to work to defy his supervisors and support his family. However, when he could no longer stand the pain, he sought a light duty job with a different supervisor. Prior to Dr. Hager's ordered-leave, Mr. Kitano had worked nine years, part-time, 21 hours a week. In June 2000, Mr. Kitano twisted his right knee at work. Eventually, he had knee surgery but without any change in symptoms. In October 2001, Mr. Kitano's left knee became painful because he was favoring his right knee. Although Mr.

Kitano's bilateral shoulder pain has been persistent, he had a "recurrence" in May 2002. After a medical evaluation, the physician returned Mr. Kitano to work in a job that only required sitting down. However, his back started hurting from sitting. He has been advised not to lift items heavier than 20 pounds. When he told Dr. Hager that he had suffered enough, the doctor took him off work. He started sick leave with a balance of 800 hours, and uses it at a rate of 21 hours a week. Presently, Mr. Kitano goes to the beach, walks in the sand and swims. He wear a right knee brace and uses a magnetic brace on his left knee. Since the right knee surgery was ineffective, Mr. Kitano does not want surgery on his left knee. He does not want to return to work.

During the physical examination, Dr. Smith noted that Mr. Kitano was "able to easily get up on the examination table." His gait was "reasonably normal, albeit slow." The knees' range of motion was limited. Neither knee showed signs of effusion. Both knees were stable and had symmetrical bulk, strength, and tone. Mr. Kitano was tender on the tip of the left shoulder acromion and supraspinatus tendon. There was no crepitation present in the rotator cuff; he made no pain complaints during the examination of this area. The right shoulder was non-tender. During the interview, Mr. Kitano gestured with his arms. He was able to "fully abduct and extend both shoulders and wave them overhead, as if painting." Yet, upon formal examination, his shoulder motion was controlled; and Dr. Smith was unable to obtain an accurate range of motion evaluation. Some limited passive range of motion was noted.

Dr. Smith also reviewed the recent x-rays of Mr. Kitano's shoulders and knees. One shoulder view showed a Type II Bigliani developmental anterior curved acromion[16] bilaterally. "Degenerative sclerosis was noted along the tuberosity of both shoulders, left greater than right." Additionally, some degenerative arthritis was present in both shoulders at the acromioclavicular joint. The knee x-rays indicated mild symmetrical narrowing of the medical joint spaces. The right knee showed a small medial patellar spur.

Based on his examination and the radiographic evidence, Dr. Smith concluded Mr. Kitano's subjective pain complaints did "not entirely correlate" with the objective findings. His shoulder condition identified by x-ray was "consistent with his age of 75 years." His shoulder abnormality was not related to his work. He did not have a rotator cuff tear. Dr. Smith also observed that the surveillance film showed Mr. Kitano using his arms and shoulders to lift a large frame out of a truck bed and carry the frame.

Pending receipt of additional x-rays of the knees, Dr. Smith did not have a final diagnosis of arthritis. However, he did not find any work-related injuries to the knees.

Finally, Dr. Smith questioned whether Mr. Kitano was "motivated by external incentives, such as avoiding work or obtaining financial compensation." He predicted Mr. Kitano would use his 800 hours of sick leave and then retire. Dr. Smith concluded no further medical care or treatment was "reasonable, appropriate, or necessary."

[16]The lateral extension of the spine of the scapula, projecting over the shoulder joint and forming the highest point of the shoulder. DORLAND'S ILLUSTRATED MEDICAL DICTIONAY 20 (28th ed. 1994).

Deposition – April 2003
(CX 6 and EX 73)

When Dr. Smith evaluated Mr. Kitano's case, he reviewed shoulder and knee x-rays obtained from Dr. Okamura. Usually Dr. Smith doesn't review the medical records prior to an examination. However, due the circumstances associated with obtaining the examination, Dr. Smith reviewed the record before examining Mr. Kitano. He also reviewed some surveillance videotape. In addition to showing Mr. Kitano lifting and carrying a frame, the video also demonstrated that Mr. Kitano could bend over and climb up and down stairs. In the video, Mr. Kitano's symptoms seem to evaporate. In particular, he observed discordance concerning the range of motion in Mr. Kitano's shoulders. He contrasted the shoulder movements and the absence of any symptoms of pain, such as grimacing, in the videotape with Mr. Kitano's controlled motion of his shoulder during the March 2003 physical examination. Even before he examined Mr. Kitano, Dr. Smith believed some discordance existed between the medical records and his presentations to physicians.

Though a condition of cumulative trauma exists, Dr. Smith requires specificity. The principle characteristic is excessive amounts of repetitive use above the level associated with daily living activities. Medical opinion is divided on the issue of whether arthritis in joints is aggravated by repetitive use. Typically, arthritis is genetically based and "accelerated by age." Physical use may actually be preventive rather than causative since it nourishes the joint. On the other hand, if a joint alignment problem exists, then repetitive use would put abnormal stress on the joint possibly causing "more progressive arthritic change." Dr. Smith observed that for the past ten years, Mr. Kitano worked a light duty job three days a week which "basically was not excessively much over activities of daily living."

If pain complaints are out of proportion with the objective findings, Dr. Smith tends to discount the complaints. In his January 2003 report, Dr. Smith indicated Mr. Kitano's alleged disability was not evidence-based. Dr. Smith may have reviewed Mr. Kitano's job description before the examination. Mr. Kitano had a light duty restriction due to his shoulder. He did not have a limitation due to his right knee. Dr. Smith is not aware of the severity of the twisting motion of Mr. Kitano's right knee in the June 2000 accident. The knee did not show extensive effusion and the diagnosis was medial collateral ligament sprain. The sprain could have caused some effusion. An x-ray and subsequent studies showed that he had pre-existing arthritis and that condition can be aggravated by overuse without any trauma. Dr. Smith acknowledged that he should have asked Mr. Kitano whether he had episodes of swelling in his right knee prior to the June 2000 accident. Mr. Kitano's symptoms warranted the knee surgery. After the surgery, the pain level in the right knee returned to the pre-operation level.

Hearing Testimony – May 2003
(TR, pages 219 to 290)

[Direct examination] After graduating from Yale medical school and initially specializing in physical medicine and rehabilitation, Dr. Smith became board certified in orthopedic surgery.[17] He was also an associate professor with the medical school in Hawaii and

[17]Without objection, I accepted Dr. Smith as an expert in orthopedic surgery (TR, page 223).

an orthopedic consultant for the University of Hawaii athletic department. While he still treats patients, the focus of his present practice is medical evaluations.

His January 13, 2003 report contains a chronology of his interaction with Mr. Kitano (EX 66). At the time of his March 25, 2003 examination of Mr. Kitano, Dr. Smith had his medical records to review. The report of the examination is EX 72. Mr. Kitano brought with him the July 12, 2002 x-rays from Dr. Okamura.

Mr. Kitano presented with multiple injuries: 1990 – neck and shoulders; June 2000 – right knee; October 2001 – left knee; and, May 2002 – recurrence of shoulder pain. Dr. Smith also reviewed the surveillance films from August 2002 and submitted a supplemental report in January 2003 (EX 67). He did not review the film from May 2003.

When he arrived for the examination, Mr. Kitano was wearing a prescribed Procare brace on his right knee and an un-prescribed magnetic brace on his left knee. Mr. Kitano was able to sit comfortably with his knees flexed. Mr. Kitano walked slowly but was able to ambulate normally. Although he stood with his knees flexed, when he was lying down, he could fully straighten out his legs. He also was able to easily get on the examining table and had no difficulty getting into a sitting position.

Neither knee showed evidence of any effusion, swelling, or inflammation of the joint. His right knee had a barely visible arthroscopic scar. His non-weight bearing range of motion in both knees was within normal limits. He was able to squat down with both knees bent approximately 90 degrees. That capability is also demonstrated in the surveillance films. Neither knee was unstable; upon moving the knee laterally and forward and back, there was no "laxity." The "medial /collateral ligament, lateral/collateral ligament, anterior cruxiate ligament, posterior cruxiate ligament were all stable and intact." The lower extremity muscles were symmetrical in bulk, strength, and tone. There was no evidence of muscular atrophy. Finally, as also shown in the surveillance video, with his knees slightly bent, Mr. Kitano could "bend his lumbo-sacral spine over 80 degrees."

During his examination of Mr. Kitano's neck and shoulders, Dr. Smith noted "subjective tenderness at the tip of the acromion of the left shoulder." In other words, when Dr. Smith pressed the area, Mr. Kitano stated it was sore. However, with some passive motions, Dr. Smith did not feel any crepitation in the area and he did not find any weakness. The right shoulder was non-tender. Concerning range of motion, Dr. Smith first observed the extent of Mr. Kitano's informal gesturing. Then, upon active examination, Mr. Kitano appeared to be controlling his range of motion. The examination range of motion "was discordant with what I noticed on gesticulation." During the passive range of motion evaluation, Mr. Kitano did not present any pain complaints; "no crepitation was noted in the rotator cuff." As a result, Dr. Smith concluded Mr. Kitano's pain complaint in the shoulder was an equivocal impingement sign. In Dr. Smith's opinion, he can not make an objective finding based on Mr. Kitano's subjective pain complaints.

The x-ray imaging from July 2002 contained three views of each shoulder. The most important image is the outlet view, which is an x-ray from the back of the shoulder that focuses on the anterior acromion. In reviewing such a study, a physician evaluates whether the anterior

acromion is developmentally curved or hooked, rather than altered traumatically. If the developmental condition exists, a person is predisposed to chronic impingement syndrome. In Mr. Kitano's case, the outlet view of both shoulders showed a curvature, Bigliani Type 2, which could cause some impingement. The left shoulder's condition was more pronounced than the right shoulder. He also observed "degenerative sclerosis of the greater tuberosity of the humerus." With this condition, impingement occurs when the shoulders are raised. On both sides, in the clavicular joint, Dr. Smith noted degenerative arthritis, characterized by spurring and some narrowing of the joint space.

The July 2002 x-rays of the right knee showed "some mild symmetrical narrowing at the medical joint side (the medial joint space between the femur and the tibia). He also noted some "tibial spurring," indicative of osteoarthritis. The left knee image contained the same narrowing, but to a lesser degree. It appeared normal for Mr. Kitano's age.

Based on his physical examination and the radiographic imaging, Dr. Smith diagnosed Mr. Kitano's shoulders' condition as: "bilateral Bigliani Type 2," which leads to chronic impingement syndrome, minor sclerosis of the greater tuberosities, and minor acromial clavicular degenerative joint disease. These changes were consistent with Mr. Kitano's age of 75. He found no evidence of a rotary cuff tear.

Concerning the right knee surgery, although he did not review any imaging data from that procedure, Dr. Smith reviewed the operative report. The surgeon observed cartilage loss under the patella and at the inner, medial side of the knee, and at the tibia plateau. The later two cartilage losses were graded as "4" which indicates "very longstanding arthritic condition" or "osteoarthritis." The physician also annotated the presence of a "complex tear" of the medial meniscus. "A complex tear is considered to be degenerative." The complex tear can be a horizontal cleavage tear. According to Dr. Smith, such a condition and osteoarthritis "exist hand-in-hand at the same time." In contrast, "a traumatic tear will usually have a through-and-through vertical tear that goes from the base all the way up to the top." A degenerative tear is a horizontal slice. The surgeon did not describe the edges of the tear, he just characterized the tear as complex. Based on these findings, Dr. Smith diagnosed osteoarthritis for the right knee.

Dr. Smith does not believe Mr. Kitano suffered a traumatic incident in 1990. The medical records from 1990 indicate that Mr. Kitano had degenerative disc disease at C5-6; specifically, "spurring of the right C5-6 neural foramina." At that time, the physician believed the neck condition was causing radicular pain from the neck to the right shoulder. However, an electromeyographic examination did not find any evidence of radiculopathy. Nevertheless, upon examination, Dr. Ma concluded the etiology of the problem was cervical. Mr. Kitano did not tell Dr. Smith about any specific injury in September 1990. Instead, he explained that he had been given heavy work, causing him to raise his arms overhead. Over the years, this work began to bother him.

Mr. Kitano indicated that on June 18, 2000, he stepped on a rock, twisted his right knee, and experienced pain in the knee. He completed his work that day and then went to Kaiser. Subsequently, in February 2001, Dr. Van Meter operated on the right knee. Dr. Smith does not

believe the June 2000 incident caused the knee condition because the operation notes indicate the presence of a degenerative meniscal tear.

In regards to the October 2001 incident, Mr. Kitano presumed the soreness in his left knee was due to increased use in relation to the right knee. Dr. Smith disagrees with that presumption. The osteoarthritis in Mr. Kitano's knee was not caused by favoring the other leg. Again, Mr. Kitano has osteoarthritis in both knees, less severe in the left knee. The left knee requires no medical treatment.

Concerning the alleged cumulative injury of May 2002, Mr. Kitano stated he was suffering a recurrence of his 1990 shoulder pains. However, Dr. Smith found no evidence of any injury. Dr. Smith attributes Mr. Kitano's shoulder aches and pains to his age and curvature development. He does have "mild impingement syndrome." Such a condition may be characterized as cumulative trauma. On the other hand, impingement syndrome may also be related to the developmental findings. Based on Mr. Kitano's description of his work and his hearing testimony,[18] Dr. Smith opined that his work did not cause a cumulative injury. At the same time, it is feasible that his work temporarily aggravated his shoulder condition.

Dr. Smith believes Mr. Kitano is malingering. He notes the "discordance" between Mr. Kitano's formal clinical presentation of "volitional-controlled motion of his shoulders" and a) the noted range of bilateral motion recorded by Dr. Okamura, b) his greater range of motion displayed at the hearing, and, c) his recorded movements during surveillance, including lifting a frame with attached concrete blocks over his head.

According to Dr. Smith, Mr. Kitano is not totally disabled. In light of the golf course range attendant job description, Mr. Kitano is capable of performing that work.

The April 2003 radiology report by Dr. Polk of Mr. Kitano's left knee indicated the knee is normal for his age. The radiologist noted medial degeneration in the right knee. In other words, the films disclosed "mild, medial compartment joint space narrowing, consistent with degeneration."

Concerning an impairment rating for Mr. Kitano's knees, Dr. Smith observed that the right knee surgery did not repair the meniscus tear. Instead, the surgeon partially removed the "ragged edge." The procedure is called a "partial medial meniscectomy. According to the Fifth Edition of the AMA guide, due to that operation, Mr. Kitano may have a two percent impairment to the lower extremity, or a one percent whole person impairment. The cause of Mr. Kitano's impairment from the June 2000 incident is the pre-existing degenerative arthritis of the right knee as established by the surgical report. The left knee has no impairment.

Dr. Smith was unable to complete a full physical exam of Mr. Kitano's shoulders due to his volitional control. However, based on the surveillance films, Dr. Smith concludes Mr. Kitano does not have a permanent shoulder impairment.

[18]Dr. Smith was present in the hearing room during Mr. Kitano's testimony (*see* TR, page 253).

[Cross examination] Although he has a psychiatric background, Dr. Smith does not treat anyone for psychiatric problems. Dr. Smith last taught in 1991 and stopped operating on patients around 1993. Twenty percent of his practice involves conservatively treating patients; the remainder involves medical/legal examinations, almost entirely in defense of workers compensation claims.

A significant component of Dr. Smith's analysis involves evaluating the objective medical evidence in comparison with the subjective symptoms to determine if the stated symptoms are consistent with the objective findings. The AMA guide does permit a designation of DRE (diagnostic related estimate)[19]-1 based on only subjective complaints. However, the associated impairment rating for that designation is zero.

Dr. Smith believes that some doctors who treat injured workers are creating victims out of the patients. Specifically, they create cases when there's no evidence. Likewise, he thinks lawyers do the same thing. He characterizes plaintiff's lawyers as "victimizers" and considers the United States to be a "nation of victims." Dr. Smith believes fraud exists in the worker's compensation program.

Although a condition called "traumatic arthritis" exists, Mr. Kitano's arthritis is degenerative. He has osteoarthritis or degeneration joint disease. Cumulative trauma requires excessive amounts of repetitive use that is significantly greater than the use associated with daily living activities. For example, a worker who uses a jack hammer to break concrete might develop a cumulative injury. Some activities with certain body parts are more productive of cumulative injury, for example, tennis elbow. Dr. Smith doesn't specifically recall whether he reviewed the National Institute of Occupational Safety and Health report on cumulative injuries.

Dr. Smith agrees that the July 2002 x-rays show the presence of arthritis in Mr. Kitano's shoulders. He also is familiar with medical record from 1990 and Dr. Ma's evaluation. He vaguely recalls that the physician imposed some physical limitations. Dr. Smith disagrees with the imposed restrictions because they were not based on medical evidence. Dr. Ma was confronted with age-related cervical degenerative disc disease. But he also found full range of motion in the shoulders and no pathology. Mr. Kitano was not disabled from using his shoulders.

The July 2002 x-rays show the presence of mild clavicular degenerative joint disease and chronic impingement syndrome. Typically, such conditions develop gradually and are not caused by an acute accident. In Mr. Kitano's case, he has developed the aches and pains of a 75 year old man. He also struggles with arthritis and developmental curved acromion, which over time, in daily living activities cause some mild impingement. It's fair to say that both activities of daily living and work contributed to the gradual development of his chronic impingement. On the other hand, based on the bulk of medical evidence, Dr. Smith opines that osteoarthritis and degenerative joint disease are related to age and genetics. Dr. Smith does not entirely agree with some physicians who theorize that arthritis in joints can be aggravated by repetitive use. Notably, in some cases repetitive exercise may prevent arthritis because the activity nourishes the cartilage. At the same time, a person with pre-existing arthritis or misalignment of the joint

[19] *See* CX 6, page 15.

may have a problem with repetitive use. However, in treating an inflamed joint due to an injury, active rehabilitation after a period of rest is the appropriate treatment.

On-going physical complaints of shoulder pain are not well documented in Mr. Kitano's medical record. Mr. Kitano continued to work after the 1990 incident. Dr. Smith is aware Mr. Kitano changed jobs in 1994. He believes it was related to personnel issues. His subjective pain complaints may have been part of an agenda to change Mr. Kitano's duty position.

Dr. Smith has treated some of his own patients just based on their subjective complaints. Sometimes, pain is the only indication of a back problem because pain generators are difficult to see in the spine.

Although Dr. Smith reviewed 12 minutes of videotape, he was not aware that the surveillance of Mr. Kitano covered 90 hours. Nevertheless, despite Mr. Kitano's clinical symptoms, he could still raise the frame over his head at home. Dr. Smith recommended a functional capacity evaluation but the test was not conducted.

After the review of the medical record and before examining Mr. Kitano, Dr. Smith developed some doubt about Mr. Kitano's credibility due to discordance in the record. He did not ask Mr. Kitano about his noted inconsistencies.

Because Dr. Smith sees so many patients for evaluation who have initially been referred to Dr. Hager, he has developed a bias. He sees a pattern of creating and maintaining disabilities without evidence. That is, the person is working, goes to Dr. Hager, and then stops working. He believes the same problem exists with Dr. Okamura, who Dr. Smith indicated was "part of the Axis of Evil."[20]

Neither Mr. Kitano nor the medical records indicated that he was having knee problems prior to the knee injury in June 2000. No restrictions relating to his knees were in place before the accident. Dr. Sandor did observe some swelling in the right knee on June 29th, which may be a sign of joint inflammation. However, Mr. Kitano also had full range of motion and walked without a limp. His knee was neither painful nor unstable and he had been able to go the beach and swim.

[Re-direct examination] Mr. Kitano is capable of doing his work as a golf course/range attendant.

Employment Records
(EX 1, EX 2, EX 4, EX 8, EX 22, EX 25, EX 43, EX 44, EX 48, EX 49, EX 53, EX 57 to EX 62, EX 64, EX 75, and EX 77 to EX 81)

July 1982 -- Mr. Kitano acknowledged his understanding of the duties and responsibilities of a maintenance mechanic. His job included light to heavy lifting.

[20]TR, page 286.

September 27, 1990 -- Mr. Kitano filed a Notice of Injury for right shoulder/upper back sprain/strain due to overuse associated with sanding and painting at various locations. He first noticed soreness on September 6, 1990. The pain progressed until he could not go to work on September 24, 1990. Mr. Kitano stated he felt numbness in his right arm and a tingling sensation from his shoulder to fingers.

October 23, 1990 -- The Employer filed a first report of injury indicating that Mr. Kitano suffered a muscle sprain/strain to his right shoulder and arm due to overuse during a long period of time.

February 1994[21] -- Mr. Kitano submitted a "voluntary request" to change his status to full-time laborer at pay step 5. According to Mr. Kitano, his doctor had reported that he was unable to perform his duties in his current position of maintenance laborer. He stated that his incapacitation would continue for an indefinite period.

February 20, 1994 -- On this day, the Employer approved a "voluntary downgrade" for Mr. Kitano. His job changed from maintenance mechanic, grade 8, step 5 to laborer, grade 2, step 5. Mr. Kitano's duties as a "laborer" at the golf course involved "simple manual tasks." The job description for a golf course range attendant laborer indicates bending, standing, and lifting light to medium objects may be required. The employee may also be asked to assist with the repair of flat tires.

June 23, 2000 -- The Employer completed a First Report of Injury indicating Mr. Kitano had twisted his right knee at the golf course cart barn and experienced right knee pain.

October 16, 2001 -- Mr. Kitano filed a compensation claim for a work-related injury to his right knee.

October 25, 2001 -- In response to an October 6, 2001 compensation claim, the Employer filed a first report of repetitive motion injury to the left knee.

May 7, 2002 -- The Employer filed a first report of Mr. Kitano's claim that repetitive overhead use of both shoulders and repeated lifting and pushing had caused pain in his shoulders. His shoulder movement was restricted. Employer contested the injury a few days later in part due to late reporting and causation.

June 25, 2002 -- Mr. Kitano filed a disability compensation claim for repetitive motion injury to both shoulders.

July 31, 2002 -- The Employer contested the shoulder injury claim.

August 5, 2002 -- The Employer controverted treatment by Dr. Hager for Mr. Kitano's right knee, noting Dr. Van Meter was the treating physician.

[21] At this time, Mr. Kitano, who was born in April 1928 (EX 4), was just a couple of months from his 66th birthday.

August 13, 2002 In an informal conference, the parties discussed the multiple claims associated with alleged injuries to Mr. Kitano's shoulders and knees.

September 3, 2002 -- Employer contested disability compensation and additional medical treatment for the right knee due to the June 18, 2000 accident because the present conditions were due to intervening non-industrial aggravation.

Payment of Compensation
(EX 30, EX 31, EX 33 to EX 35, EX 38, EX 41, and EX76)

The Employer paid Mr. Kitano temporary total disability from September 24, 1990 to October 2, 1990 and October 6, 1990 to December 2, 1990 at the compensation rate of $268.81 based on an average weekly wage of $403.12. Mr. Kitano returned to work on December 3, 1990.

Due to the June 18, 2000 injury, the Employer paid temporary total disability compensation at the minimum weekly rate of $225.32 for June 19 and 20, 2000 and February 16, 2001 to April 8, 2001. At the time of his accident, Mr. Kitano's average weekly wage was $248.39. Mr. Kitano returned to work on April 9, 2001. Temporary partial disability compensation was initiated on the same day and was paid at the weekly rate of $61.32 through July 29, 2001.

Surveillance

Mr. Ivan Alatan – Hearing Testimony and Declaration
(TR, pages 199 to 211 and EX 71)

[Direct Examination] Mr. Alatan is the vice president of McCormick Investigations, which conducts surveillance work. He has about three years experience.

In August 2002 and May 2003, the company was asked to conduct surveillance of Mr. Kitano. Two surveillance reports were made (EX 59 and EX 82). Several employees of the company, including Mr. Brian McCormack (EX 69) and Mr. Roy Kupihea (EX 70), obtained the video with an 8mm camera. The surveillance over the course of several days for both periods has been condensed on two CD ROMs attached to the record (EX 59 and EX 82). None of the video has been altered.

[Cross examination] The total surveillance effort for both periods probably took about 90 hours. On one day, May 6, 2003, they did not observe any activity. The total amount of condensed video runs about 18 minutes.

Summary of Condensed Surveillance Video[22]
(EX 59 and EX 82)

August 12, 2002[23] -- At 10:10 a.m. Mr. Kitano places a wooden frame into the back of a red pick-up truck. The frame is about three feet wide and six feet tall; its two upright supports have attached cinder block footings. At 10:14 a.m., he drives the truck away and arrives at another location at 10:18 a.m. Mr. Kitano slides the frame part way out of the truck bed, bends over, pulls the frame upright, lifts the entire frame off the ground, and carries the frame away. He appears to have no difficulty in accomplishing these tasks. His shoulder and back movements are fluid and made without hesitation. His ability to walk seems unencumbered by any knee or leg problem. Once he lifts the frame and places a weight load on his shoulder, body, and knees, Mr. Kitano demonstrates no pain symptoms and there is no change in his gait. Mr. Kitano departs at 10:26 a.m. after replacing a ladder at the side of a building.

August 13 and August 14, 2002[24] -- At various times, Mr. Kitano enters the front driver's side seats of a white corolla and a red pick-up truck without any difficulty or apparent problem with either knee.

August 21, 2002[25] -- Between 8:51 a.m. and 12:41 p.m., Mr. Kitano carries various items of apparent debris, including folded paper and small boxes of trash from a second story landing of a two story building, which appears to be an apartment building, downstairs to a location off camera. He makes about six trips. When he first comes down the stairs at 8:51, his t-shirt is dry. About 40 minutes later, when he brings down a second load of debris, the front and back of his t-shirt appear to be fairly wet, as if drenched with sweat. Although he descends the outside stairs without difficulty, each time he climbs back up the stairs to the second story landing, his pace is much slower. Mr. Kitano is wearing a black brace on his right knee. He walks with barely a slight limp apparently due to the right knee. No problem with the left knee is noticeable. At 12:45 p.m., just prior to departing in a small red pick-up truck, Mr. Kitano easily lifts a five gallon bucket of cleaning supplies up over the side of the truck and places it in the truck bed.

May 5, 2003[26] -- At 8:55 a.m., Mr. Kitano enters a red pick-up truck without difficulty.

May 7, 2003[27] -- Between 10:22 a.m. and 10:25 a.m., Mr. Kitano trims a chest-high hedge with a large, two handle pruning shears. At times, to trim the opposite side, Mr. Kitano

[22]This summary is based on my review of the videotape CDs, EX 59 and EX 82.

[23]The attached narrative report indicates that between 9:10 a.m. to 10:09 a.m. and 10:29 a.m. to 5:56 p.m., August 12, 2002, no outside activity was observed (EX 59, EX 69, EX 70, and EX 71).

[24]Between 6:05 a.m. to 10:21 a.m. and 10:26 a.m. to 11:22 a.m. August 13, 2002, and 7:00 a.m. to 9:44 a.m. and about 10:00 a.m. to 3:00 p.m., August 14, 2002, no outside activity was observed (EX 59, EX 69, EX 70, and EX 71).

[25]Between 1:27 p.m. and 3:48 p.m., August 21, 2002, no outside activity was observed (EX 59, EX 69, EX 70, and EX 71).

[26]No outside activity observed 6:09 a.m. to 8:38 a.m. and 12:00 p.m. to 3:00 p.m. (EX 82).

leans over the hedge, arches his shoulders and extends the pruning shears over the hedge and down the side. Mr. Kitano removes small cut branches with his right hand. His movements are fluid and without hesitation. He displays no pain symptoms and favors neither shoulder.

At 10:53 a.m., for several minutes, Mr. Kitano trims a waist high hedge with a pair of small shears, using his right hand. Again, at times, he reaches over the top of the hedge to trim branches on the opposite side. He moves without hesitation and does not display any apparent signs of pain.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Stipulations of Fact

The parties have stipulated to the following facts (TR, page 43): a) On September 6, 1990 and June 18, 2000 an employer-employee relationship existed between the parties; b) On June 18, 2000, Mr. Kitano was involved in an accident at work; and, c) The June 18, 2000 accident arose out of and in the course of his employment with the Employer.

Preliminary Finding

Based on counsel's representation in the closing brief, the Claimant no longer contests the disability compensation rate and concedes that the appropriate weekly compensation rate is $225.32 as determined by the Employer for the temporary disability payments in June 2000 (*see* CX 1 and EX 31).

A. Right Shoulder Injury/Cumulative Bilateral Shoulder Injury

In June 2002, Mr. Kitano filed a compensation claim for a bilateral cumulative shoulder injury. In response, the Employer has raised some objections that are unique to the right shoulder. In light of these objections and considering the nature of the cumulative bilateral shoulder injury, I will consider the claim in terms of its components: the right shoulder and the left shoulder.

As part of his cumulative bilateral shoulder injury, Mr. Kitano claims that he has experienced worsening pain in his right shoulder that was injured during his employment with the employer in 1990. The Employer asserts Mr. Kitano's claim is barred because he failed to provide both a timely notice of the worsening right shoulder condition and a timely claim for disability compensation for such an injury. The Employer also implicitly challenges whether Mr. Kitano's present claimed right shoulder problem is related to the 1990 injury. Finally, the Employer contests the nature and extent of Mr. Kitano's claimed right shoulder injury and his claim for medical benefits.

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[27]No outside activity observed on May 6, 2003 between 7:09 a.m. and 3:40 p.m.; on May 7, 2003, no outside activity noted between 6:42 a.m. and 8:55 a.m. and 10:57 a.m. and 3:00 p.m.; on May 9, 2003, other than a momentarily observation, no activity noted from 7:00 a.m. to 4:00 p.m.; and, May 10, 2003, between 10:50 a.m. and 3:50 p.m. no visible activity noted (EX 82).

Issue No. 1 – Timely Notice of Injury and Claim

Notice of Injury

Section 2 (2) of the Act, 33 U.S.C. § 902 (2), defines a compensable injury as an accidental injury arising out of and in the course of employment. The term, "injury" is considered to encompass both physical harm and conditions which indicate something had gone wrong within the human frame. *Wheatley v. Adler,* 407 F.2d 307 (D.C. Cir. 1968). If something unexpectedly goes wrong within the human frame, whether by lesion or change in any part of the system, which produces harm, pain, or lessened facility of natural use, even if it occurs in the course of usual and ordinary work, a claimant has sustained an accidental injury. *McGuigan v. Washington Metropolitan Area Transit,* 10 BRBS 261, 263 (1979) and *Gardner v. Bath Iron Works Corp.,* 11 BRBS 556, 558 (1979), *aff'd sub. nom, Gardner v. Director, OWCP,* 640 F.2d 1385 (1st Cir. 1981). If an initial medical condition progresses into complications more serious than the original injury, the additional complications represent compensable injuries. *Andras v. Donovan,* 414 F.2d 241 (5th Cir. 1969). An injury may develop over a period of employment and still be considered accidental. *Gencarelle v. General Dynamics Corp*., 22 BRBS 170 (1989), *aff'd*892 F.2d 173 (2d Cir. 1989) (synovitis of the knee, an arthritic condition aggravated by repeated bending, stooping, and climbing on the job, may be considered an accidental injury rather than an occupational disease). According to the Benefits Review Board ("Board" or "BRB"), credible complaints of subjective symptoms and pain may be sufficient to establish an injury under the Act. *See Sylvester v. Bethlemhem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom., Sylvester v. Director,* OWCP, 681 F.2d 359 (5th Cir. 1982). A claimant's credible complaints of pain alone may be sufficient to establish an inability to return to work. *Anderson v. Todd Shipyards Corp*., 22 BRBS 20 (1989). Finally, a claimant suffers an injury if his employment aggravates a non-work-related, underlying disease or condition to the extent the claimant suffers incapacitating symptoms. *Preziosi v. Controlled Indus.*, 22 BRBS 468 (1989).

Recognizing that injuries under the Act include both traumatic accident-induced damage and cumulative physical harm, Section 12 (a) of the Act, 33 U.S.C. § 912 (a) requires that a claimant provide notice of a work-related injury within 30 days of either a) the date of injury, or b) within thirty days[28] after a claimant becomes reasonably aware, or should have become aware, of the relationship between the disability and employment. Failure to provide such notice of injury will bar a claim for disability compensation under the Act unless the employer was actually aware of the injury or fails to establish that it was prejudiced by the lack of notice. Section 12 (d). "To establish prejudice, the employer bears the burden of proving by substantial evidence that it has been unable to effectively investigate some aspect of the claim due to the claimant's failure to provide timely notice pursuant to Section 12." *Steed v. Container Stevedoring Co.* 25 BRBS 210, 216 (1991).

[28]The requisite notice period is one year for an occupational disease. Mr. Kitano is not claiming an occupational disease (TR, page 290) and his claimed injuries do not seem to fall within the category of occupational disease. *See Steed v. Container Stevedoring Co.* 25 BRBS 210, 214-16 (1991) (gradual work-related worsening of lumbar stenosis should be considered an accidental injury rather than an occupational disease because the employee's activities were not singular or peculiar to his employment).

The first portion of Section 12 (a) relates to an injury caused by a traumatic accident at work. In that situation, the date of the work-related accident sets the date of the injury for purposes of the Section 12 (a) 30 day notice requirement.[29] The second part of Section 12 (a) covers injuries alleged to have developed over the course of employment due to cumulated physical stress. In that situation, the appropriate associated date of injury occurs when the long term damage becomes manifest and the claimant reasonably becomes aware of the relationship between the bodily harm and his or her employment. *See Travelers Insurance Co. v. Cardillo,* 225 F.2d 137 (2d Cir.), *cert. denied,* 350 U.S. 913 (1955) and *Thorud v. Brady-Hamilton Stevedore Co., et. al.,* 18 BRBS 232 (1987).

Since Mr. Kitano's claimed recurrent right shoulder condition falls into the later category of injury, cumulative harm, I turn to the medical record to determine when he reasonably should have become aware of a relationship between his recurrent right shoulder problems and work.

According to Mr. Kitano, over the course of years between 1994 and 2002, his right shoulder, along with his left shoulder, developed worsening pain. On May 14, 2002, Dr. Hager examined Mr. Kitano and found tenderness in the muscles of Mr. Kitano's right shoulder. The same condition was present in the left shoulder. Based on Mr. Kitano's overhead work and lifting as a golf cart attendant, Dr. Hager believed the gradual stress of Mr. Kitano's repetitive work caused a cumulative injury in the form of "derangement" in his right shoulder. To confirm his diagnosis, Dr. Hager referred Mr. Kitano to a shoulder specialist. In July 11, 2002, based on Dr. Hager's referral, Dr. Okamura confirmed Mr. Kitano had problems with his right shoulder. Dr. Okamura suggested the right shoulder condition related back to Mr. Kitano's 1990 overuse injury. In light of this combination of medical evaluations, Mr. Kitano's long term suspicion that his golf cart attendant work was bothering his shoulders certainly became medically manifest by July 11, 2002. Reasonably, Mr. Kitano should have realized that a relationship existed between his worsening right shoulder pain and his employment at the conclusion of Dr. Okamura's evaluation. As a result, I will use July 11, 2002 as the date of injury for Mr. Kitano's alleged cumulative right shoulder injury.

According to Mr. Kitano's employment record, on May 7, 2002, the Employer filed a first report that Mr. Kitano believed he had suffered a repetitive use injury to his shoulders. The record does not indicate how the Employer learned about Mr. Kitano's alleged cumulative shoulder injury prior to even his visit to Dr. Hager. I really don't have to address that issue. Clearly, by the determined date of injury of July 11, 2002 (and for that matter, the first visit with Dr. Hager on May 14, 2002), the Employer had received notice of the cumulative right shoulder injury. Thus, the Employer had timely notice of his injury.

In light of the diverse medical opinions concerning the nature of Mr. Kitano's right shoulder problem, I also note that if his right shoulder condition is simply a long-term, natural consequence of his overuse injury in 1990, the Employer had timely notice of the primary injury in September 1990.

[29]When one injury arises out of an accident that has been reported, a claimant does not have to give a separate notice of other injuries resulting from the same incident. *Thompson v. Lockheed Shipbuilding & Constr. Co.,* 21 BRBS 94 (1988).

Finally, even if Mr. Kitano did not provide timely notice of his recurrent right shoulder injury, the Employer has failed to present substantial evidence that it was specifically prejudiced by the associated delay as required by Section 12 (d). In this case, any delay by Mr. Kitano in reporting his recurrent right shoulder problems does not appear to have adversely affected the Employer's development of its defense. Notably, in its defense against liability, the Employer presented extensive evidence, including Mr. Kitano's decades-long medical record. Additionally, the Employer was able to have a physician examine Mr. Kitano's claimed cumulative shoulder injury and consider the extensive medical record. Further, Mr. Kitano's supervisor was still available to describe his assigned duties and indicate whether he presented any reports of right shoulder pain.

Notice of Claim

In a manner similar to Section 12 (a), under Section 13 (a), 33 U.S.C. § 913 (a), a claim for compensation will be barred unless it is filed within one year[30] after the injury. If an employer has voluntarily paid compensation without an award, a claim may also be filed within one year after the date of the last payment.

Based on the language of Section 13 (a), the U.S. Court of Appeals for the Ninth Circuit has concluded that the Section 13 (a) claim filing statute of limitation starts to run when the claimant becomes aware of the full character, extent and impact of the harm. *J. M. Martinac Shipbuilding v. Director, OWCP,* 900 F.2d 180, 183 (9th Cir. 1990), *citing, Todd Shipyard Corp. v. Allan,* 666 F. 2d 125, 127 n. 3 (9th Cir.), *cert. denied,* 459 U.S. 1034 (1982). That is, the claimant must be aware of both a) the relationship between the injury and the employment, and b) the adverse impact the injury has on his earning power. *Id. See also Abel v. Director, OWCP,* 932 F.2d 819, 822 (9th Cir. 1991). The court explained its interpretation served public policy "by not discouraging workers' attempts to return to work and by not encouraging premature claims of permanent disability."[31] *Martinac,* 900 F.2d at 184. Experiencing pain after an accident, especially when the pain does not prevent a claimant from retuning to work, does not put the employee on notice that his or her long-term earning capacity has been adversely affected by the injury. *Paducah Marine Ways v Thompson,* 82 F.3d 130, 135 (6th Cir. 1996).

Although following his visit with Dr. Hager in May 2002, Mr. Kitano may have begun to understand the full nature and extent of his problem, he did not know the full impact of that condition until the follow-up examination on July 26, 2002. At that time, Dr. Hager advised Mr. Kitano that due to the condition of his shoulders and knees, he could no longer work as a golf cart attendant. As of July 26, 2002, Dr. Hager placed Mr. Kitano in non-duty status. According to Dr. Hager, he would have taken the same action even if Mr. Kitano only had shoulder problems. Prior to Dr. Hager's mandate, Mr. Kitano continued to work with his pain. He did not fully understand the impact his shoulder condition would have on his earning power until Dr.

[30]For an occupational disease, the claim filing period is extended to two years. Section 13 (b) (2).

[31]In adopting this standard, another court commented "The impairment standard does not penalize employees who attempt, even though they may experience some pain, to return to work after apparently recovering from an injury." *Paducah Marine Ways v. Thompson,* 82 F.3d 130, 134 (6th Cir. 1996).

Hager stopped him from working. Accordingly, I find that on July 26, 2002, Mr. Kitano finally understood the full nature, extent, and impact of his shoulder condition.

Apparently based on his initial visit with Dr. Hager, even before he understood the full impact of his shoulder condition on his earning power, Mr. Kitano filed a claim for cumulative injury to his shoulders on June 25, 2002. Accordingly, Mr. Kitano's notice of claim is timely under the Act.

Finally, to the extent that Mr. Kitano's present condition is simply a natural continuation of the right shoulder injury of 1990, his claim for additional compensation is not barred. According to the BRB, when a claim is timely filed under Section 13 (a) of the Act, but never adjudicated, the claim remains open and pending until an order is issued. *Lewis v. Norfolk Shipbuilding and Drydock Corp.* 20 BRBS 126 (1987)[32] Mr. Kitano filed his initial claim for an impaired right shoulder on September 27, 1990. The Employer voluntarily paid him temporary total disability compensation for several periods of absences through December 2, 1990. Then, Mr. Kitano returned to full-time work and his claim was never adjudicated. Consequently, his September 1990 claim remains open in regards to any right shoulder condition that relates to the overuse in 1990.

Issue No. 2 – Causation

Having determined Mr. Kitano filed a timely notice of, and claim for, his present shoulder condition, I now turn to the issue of whether his right shoulder pain that he presented to Dr. Hager in May 2002 is work-related.

Absent substantial evidence to the contrary, Section 20 (a) of the Act, 33 U.S.C. § 920 (a), establishes a presumption that a disabling condition is causally related to employment if: a) the claimant suffered a harm; and, b) employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the harm or condition. *Gencarelle v. General Dynamics Corp.* 22 BRBS 170 (1989), *aff'd* 892 F.2d 173 (2 Cir. 1989). In other words, the Act establishes a causation presumption that such an injury is work-related.

To rebut the Section 20 (a) causation presumption, the employer must present specific medical evidence proving the absence of, or severing, the connection between the bodily harm and the employee's working condition. *Parsons Corp. v. Director, OWCP (Gunter)*, 619 F.2d 38 (9th Cir. 1980). The U.S. Circuit courts have rendered different views on the extent of such evidence. In *Brown v. Jacksonville Shipyards, Inc.*, 554 F.2d 1075 (11th Cir. 1990), the U.S. Court of Appeals for the Eleventh Circuit required the employer to produce evidence which ruled out the possibility of a causal relationship between the claimant's employment and injury. On at least one occasion, the BRB has taken a similar position. *Quinones v. H. B. Zachery, Inc.*, 32 BRBS 6, (1998). On the other hand, in *Conoco, Inc. v. Director, OWCP [Prewitt]*, 194 F.3d 684 (5th Cir. 1999), the U.S. Court of Appeals for the Fifth Circuit rejected the "rule out" standard.

[32]In this case, the claimant filed a timely disability claim prior to the employer's termination of voluntary disability payments. When the claimant filed for additional benefits several years later, the employer asserted the subsequent claim was time-barred. The Board disagreed and found that the original timely filed claim remained opened since it was never adjudicated

Instead, according to that court, an employer must produce evidence that a reasonable mind might accept as adequate to support a conclusion that the accident did not cause the injury.

Since Mr. Kitano's case arises in the Ninth Circuit, I turn to the case of *Stevens v. Todd Pacific Shipyards*, 14 BRBS 626 (1982) *aff'd mem.* 722 F.2d 747 (9th Cir. 1983), *cert. denied* 467 U.S. 1243 (1984), which tilts towards the *Conoco* standard. In *Stevens*, the appellate court affirmed a determination that when a work-related accident occurs which is followed by an injury, the employer need only introduce medical testimony controverting causation and does not have to prove another causation agent to rebut the presumption.

Once the Section 20 (a) presumption is rebutted, it no longer controls the adjudication. *Swinton v. J. Frank Kelly, Inc*. 554 F.2d 1075 (D.C. Cir.) *cert. denied* 429 U.S. 820 (1976). Instead, all the evidence in the record must be evaluated and the causation issue is then determined based on the preponderance of the evidence. *Noble Drilling Co. v. Drake*, 795 F.2d 478 (5th Cir. 1986).

If a claimant establishes the existence of a compensable injury, then through the causation presumption under Section 20 (a), the employer remains responsible for all natural consequences of that injury, whether they occur at work or away from work,. *Bludworth Shipyards v. Lira,* 700 F.2d 1046 (5th Cir. 1983) and *Kooley v. Marine Industries N.W.,* 22 BRBS 142 (1989). As a result, when an employee sustains an injury at work which is followed by the occurrence of a subsequent injury or aggravation, the employer is liable for the entire disability and the medical expenses due to both injuries if the subsequent injury or aggravation is the natural and unavoidable result or consequence of the original work-related injury.[33] *Bludworth,* 700 F.2d at 1050.

The employer may sever the work-related connection of subsequent claimed injuries generated by the statutory presumption. To be relieved of liability for that portion of the disability attributable to the second injury or aggravation, the employer may present either a) substantial contrary evidence of an absence of a connection; or, b) evidence of an intervening cause, such as intentional conduct, for the subsequent injury. *Merrill v. Todd Pacific Shipyards Corp.* 25 BRBS 140, 144 (1991), *James v. Pate Stevedoring Co.* 22 BRBS 271 (1989), and *Bailey v. Bethlehem Steel Corp.* 20 BRBS 14 (1987). The court in *Bludworth,* 700 F.2d at 1050, further explained, "[a] subsequent injury is compensable if it is the direct and natural result of a compensable primary injury, as long as the subsequent progression of the condition is not shown to have been worsened by an independent cause."

Finally, if a claimant's employment aggravates a non-work-related, underlying disease or condition so as to produce incapacitating symptoms, the resulting disability may be compensable. *See Gardner v. Bath Iron Works*, 11 BRBS 556 (1979), *aff'd sub nom. Gardner v. Director, OWCP*, 640 F.2d 1385 (1st Cir. 1981).

[33]For example, in *Merrill v. Todd Pacific Shipyards Corp.,* 25 BRBS 140 (1991), based on a treating physician's opinion that no new injury occurred when the claimant suffered severe back pain when doing yard work, the Benefits Review Board affirmed the administrative law judge's finding that the claimant's recurring back problems were natural and unavoidable consequences of his employment.

With these principles in mind and due to Mr. Kitano's particular medical history and the nature of his claimed present right shoulder injury, I must first go back to 1990 and make specific findings concerning the physical ailments he experienced at that time. After establishing the condition of Mr. Kitano's right shoulder in 1990, I will return to the May 2002 shoulder pain and his present claim.

1990 Right Shoulder Injury

Background and Medical Opinion

Around September 1990, Mr. Kitano worked for the Employer as a full-time maintenance laborer. According to Mr. Kitano, during this period, the Employer assigned several jobs that required carrying drywall, painting and sanding overhead for prolonged periods, and digging post holes. Due to this activity, Mr. Kitano began to experience pain in his right shoulder around mid-September 1990. He continued working for several days until the pain became significant.

On September 24, 1990, he sought medical treatment at the Kailua Clinic with Dr. Bender. Mr. Kitano reported radiating right shoulder and arm pain and numbness in his right hand and fingers. Dr. Bender found tenderness in the right trapezius muscle group in the shoulder and noted protected neck movements due to right scapular pain. A few days later, a cervical x-ray revealed some spurring impingement on the right C5-6 neural foramen. Dr. Bender diagnosed trapezius muscle strain and possible nerve impingement.

Between October 1990 and February 1992, Dr. Bhat treated Mr. Kitano for his neck and shoulder problem. Although he found no direct injury to the right shoulder, Dr. Bhat noted on physical examination tenderness of Mr. Kitano's right shoulder lateral trapezius. He believed the cervical x-ray showed degenerative changes at C5-6. An EMG did not identify nerve impingement at C5-6 but suggested a motor deficit at C7. At the conclusion of his treatment of Mr. Kitano in February 1992, Dr. Bhat diagnosed stabilized cervical radiculopathy with chronic neck pain. He limited Mr. Kitano to light duty.

In conducting an EMG study in November 1990, Dr. Saito noted Mr. Kitano's pain complaints. However, other than a possible C-7 sensory deficit, both the EMG and physical examination were essentially normal.

Dr. Pang examined Mr. Kitano in April 1991. Based on an x-ray, EMG study and physical examination, he diagnosed mild degenerative changes at C5-6 with right side spurring and cervical radiculopathy. Because Mr. Kitano declined surgical intervention, Dr. Pang advised him to avoid lifting heavy objects and doing repetitive overhead work with his right arm.

In June 1991, after an examination, Dr. Flick reached the same diagnosis: degenerative cervical spine disease and cervical radiculopathy. He also recommended permanent light duty.

In February 1992, Dr. Ma conducted a full examination, reviewed test results and considered the medical record. He found muscle tightness in Mr. Kitano's shoulder and limited range of motion. The x-ray showed a degenerative, herniated C5-6 disc with osteophytic

encroachment, particularly on the right side. Although neither the EMG nor physical examination identified an obvious sensory deficit, Dr. Ma believed Mr. Kitano's symptoms were consistent with minor radiculopathy of the C-6 nerve. Concerning the etiology of Mr. Kitano's shoulder complaints, Dr. Ma opined that his symptoms were manifested signs of a gradually developing degenerated, herniated C5-6 disc. Dr. Ma also suggested Mr. Kitano remain in light duty status to avoid aggravation of his degenerative disc.

Finally, based on his review of the medical record, Dr. Smith believes Mr. Kitano had a pre-existing degenerative disc disease with right side spurring into the neural foramen in September 1990. Considering Mr. Kitano's age, that condition was not abnormal. Additionally, the disc disease was not related in any way to Mr. Kitano's work. Dr. Smith noted the absence of any traumatic incident or accident in 1990. In the absence of objective evidence, and considering the normal EMG, Dr. Smith believed Mr. Kitano's complaint of injury at that time was speculative. He suggested the complaint may have been part of Mr. Kitano's agenda to obtain a change in jobs or limited duty.

Discussion

The first issue associated with Mr. Kitano's condition in September 1990 is whether he experienced right shoulder pain at that time. Unlike the issue of causation under Section 20 (a), no presumption exists in Mr. Kitano's favor in regards to whether an injury is actually present. *See Devine v. Atlantic Container Lines, G.I.E.,* 25 BRBS 15 (1990).

While not actually questioning Mr. Kitano's pain complaints, in November 1990, Dr. Saito reported his physical examination of Mr. Kitano and most of the EMG results were normal.

To the extent that Dr. Saito's opinion represents a determination that no right shoulder harm was present in September 1990, his conclusion is overwhelmed by the preponderance of the well documented and reasoned opinions of all the other physicians who actually examined Mr. Kitano between 1990 and 1992 and did not express any concern about the accuracy or veracity of his pain presentation. Based on Mr. Kitano's pain complaints, their physical examinations, and radiographic evidence, Dr. Bender, Dr. Bhat, Dr. Pang, Dr. Flick and Dr. Ma diagnosed cervical radiculopathty and changed his work status to limited duty. Likewise, twelve years later, Dr. Smith did not dispute that Mr. Kitano had experienced right shoulder pain in 1990; he only questioned whether Mr. Kitano had actually suffered a traumatic injury. Accordingly, the preponderance of the medical opinion establishes that in September 1990, something went wrong with the right side of Mr. Kitano's body from his neck to his hand in the form of pain in the shoulder and arm and numbness in the hand.

Having determined Mr. Kitano had an "injury" in September 1990, I next address whether that injury was related to his work. Prior to his demonstrative pain in September 1990, Mr. Kitano had been engaged in extensive and arduous lifting and overhead work, dry-walling, sanding, and painting. Such work could reasonably have caused Mr. Kitano's presenting right neck, arm and hand pain. As result, I conclude that Mr. Kitano is able to invoke the Section 20 (a) presumption that his right shoulder problem in 1990 was work-related.

However, through Dr. Ma's documented and reasoned medical opinion, as supported by Dr. Smith's conclusion to essentially the same effect, the Employer has rebutted that presumption. According to Dr. Ma, Mr. Kitano's presenting symptoms were due to his gradually developing C5-6 disc disease. To the same effect, Dr. Smith also suggested Mr. Kitano's condition only involved the gradual development of his pre-existing cervical problem.

Since the Section 20 (a) causation presumption has been rebutted, I return to a review of all the medical evidence and reach several conclusions. First, based on the consensus of Dr. Bender, Dr. Bhat, Dr. Pang, Dr. Flick, Dr. Ma, and Dr. Smith, I find that prior to September 1990, Mr. Kitano had developed degenerative disc disease at C5-6, which included some bony encroachment into the right side of the neural foramen.

Second, although the encroachment was not extensive enough to produce positive EMG test results, I conclude based on the combined opinions of Dr. Bender, Dr. Bhat, Dr. Pang, Dr. Flick, and Dr. Ma that the C5-6 encroachment was sufficient to cause some right-sided cervical radiculopathy.

Third, the medical record through 1992 is insufficient to establish that Mr. Kitano's work either caused or contributed to his degenerative disc and associated encroachment. As a result, neither the degenerative disc disease nor right side encroachment at C5-6 are work-related.

Fourth, based on the consensus of the medical opinion, and in particular Dr. Ma's finding, I conclude Mr. Kitano's presenting symptoms in September 1990, including his right shoulder pain, were related to his pre-existing C5-6 degenerative disc disease and associated right-side neural encroachment.

Fifth, with the exception of Dr. Ma, the other physicians who treated Mr. Kitano between 1990 and 1992 did not specifically address the issue of work-related aggravation of his cervical disease. Nevertheless, while Mr. Kitano's right shoulder pain and arm pain were related to his pre-existing degenerative disc disease, I also find based on the circumstantial evidence that in September 1990, Mr. Kitano's intense lifting and overhead work as a maintenance laborer aggravated his pre-existing degenerative disc disease. Between 1977 and September 1990, Mr. Kitano performed a wide array of manual tasks as a maintenance laborer and did not experience any disabling pain. Also, apparently during this same period, his disc disease gradually developed. Then, in September 1990, Mr. Kitano was required to repair walls and ceilings by himself. To accomplish these assignments, he had to lift heavy dry wall and engage in extensive overhead work, sanding and painting. In light of the subsequent and significant work limits imposed by Dr. Bhat and Dr. Pang, these specific types of activities were inappropriate for Mr. Kitano because they apparently would aggravate his degenerative disc disease and C5-6 encroachment. Additionally, in terms of the pain development, contrary to a gradual natural worsening of his cervical disc disease and onset of reflective shoulder pain, in September 1990, Mr. Kitano experienced a rapid and intense development of shoulder and arm pain. Within a week or two of its onset in September 1990, Mr. Kitano became disabled by the right shoulder and arm pain. This rapid pain development occurred within the context of no reports in the medical record of right shoulder pain or problems prior to September 1990.

I have considered that Dr. Ma and Dr. Smith believed Mr. Kitano's symptoms were simply the manifesting signs of his gradually developing degenerative disc disease and not related to his work. However, their opinions have diminished probative value due to insufficient reasoning. Specifically, in identifying only the gradual development of disc disease as the etiology of the symptoms, Dr. Ma and Dr. Smith failed to explain how their conclusions were consistent with key components of Mr. Kitano's work and symptomology. Notably, they did not address a) Mr. Kitano's history of a pain free right shoulder until September 1990, b) the significant increase in the nature and extent of his physical work in the fall of 1990; and, c) the apparently rapid and intense development of his right shoulder pain.

Possibly, regardless of his work, Mr. Kitano's disc disease may have developed sufficiently by September 1990 to start causing him some pain problems. Yet, Mr. Kitano's pain moved from noticeable to disabling within a matter of weeks. This pattern of pain development circumstantially indicates that more than mere coincidence was at play in September 1990 when the pain symptoms suddenly developed at the same time Mr. Kitano was engaged in some extraordinary physical labor. In light of these considerations, contrary to the opinions of Dr. Ma and Dr. Smith, I find the circumstantial evidence on this issue establishes that Mr. Kitano's September 1990 wall and ceiling repair work aggravated his pre-existing degenerative disc disease and right side cervical encroachment to the extent he suffered disabling right neck, shoulder and hand pain.

One final note before departing the early 1990s. By December 3, 1990, the aggravation of Mr. Kitano's degenerative disc disease had been sufficiently diminished to permit his return to limited duty and no longer represented a totally disabling condition. Around February 1992, Dr. Bhat, the treating physician concluded the right shoulder pain had resolved and stabilized. About the same time, Dr. Ma also indicated that absent any subsequent aggravation, Mr. Kitano's cervical condition did not require any additional medical treatment. Based these medical opinions, I find that by February 1992 Mr. Kitano had reached maximum medical improvement in regard to the September 1990 aggravation of his degenerative disc disease.

2002 Right Shoulder Injury

Background and Medical Opinion

In terms of employment, between 1992 and 1994, Mr. Kitano remained in a full-time, limited duty capacity as a maintenance laborer. In 1994, he moved to the golf course to continue his limited duty. Shortly after his reassignment, Mr. Kitano shortened his work week to part-time, 21 hours a week, due to income issues with the Social Security Administration. He continued his part-time work as a golf cart attendant until July 26, 2002.

During the course of his work day as a golf cart attendant, Mr. Kitano completed numerous physical tasks. Each morning, he carried a gas-powered blower on his shoulder for about a half an hour to clear the patio area of debris. The blower weighed about 18 pounds. About three times a day, he would assist his partner in retrieving golf balls from the driving range. While his partner rode the tractor-sweeper, Mr. Kitano collected golf balls from under the bushes. After collecting the driving range golf balls, they placed the balls in a washer using

buckets that could weigh up to 18 pounds. Once the golf balls were clean, they took the golf balls to the pro shop in a large bucket that they both usually carried. Occasionally, Mr. Kitano had to replace flat golf cart tires. The procedure required him to kneel down. When he emptied the trash, Mr. Kitano had to lift a 25 to 30 pound trash bag up to about five feet to place it in the trash receptacle. Over the course of the day, when the golf carts returned to the barn, Mr. Kitano would recharge the vehicles by unwinding overhead electrical cords and attaching the cords to the cart. Typically, he recharged 40 to 50 carts a day.

In regards to the condition of his right shoulder, Mr. Kitano testified that his shoulder pain persisted throughout his employment. However, Mr. Kitano enjoyed work and stayed busy to forget the pain. The overhead work did not really aggravate his right shoulder; the pain in his right shoulder, at about the four to five level, did not worsen. When he had to lift heavy items, Mr. Kitano would use his hip and knee Mr. Kitano stopped working in the summer of 2002 due to Dr. Hager's recommendation and the combined pain of his shoulders and knees. If he had not experienced the knee pain, Mr. Kitano could have continued working with just the shoulder pain.

Medically, between February 1992 and April 2002, Mr. Kitano's medical record contains little mention of any significant or treated difficulties with his right shoulder. He reported only a ruptured disc on a 1993 health survey. In a 1995 surgical questionnaire, Mr. Kitano reported being bothered by neck and back pain. The associated medical history noted degenerative joint disease. In February 2000, Mr. Kitano presented to Dr. Lum with *left* shoulder pain. The physician diagnosed bursitis.

On May 14, 2002, Mr. Kitano reported bilateral shoulder pain to Dr. Hager. Mr. Kitano described his work at the golf course; recalled that he had suffered an injury to his right shoulder in 1990 (although he appears to have emphasized involvement of his left, rather than right, shoulder); and, indicated he has experienced gradually increasing bilateral shoulder pain. His left shoulder had the most pain. In particular, the pain in Mr. Kitano's right shoulder was 5 (significant discomfort);[34] the pain in his left shoulder reached 9 (almost unbearable, extremely severe pain). Upon examination, Dr. Hager confirmed tenderness in the right shoulder muscles and a mild range of motion limitation. Mr. Kitano's left shoulder was also tender and had greater range of motion limitations due to pain. A subsequent CT scan only showed osteoarthritis in the thoracic spine. On July 26, 2002, due to increasing knee and shoulder pain that was getting worse everyday, Dr. Hager removed Mr. Kitano from work until the causes of his problems could be established. He was especially concerned about the impact of work activities on Mr. Kitano's knees. Even if the sole problem had been the shoulders, Dr. Hager would still have placed Mr. Kitano off duty because he should not engage in repetitive overhead work or lifting above his shoulders. During the examinations in January and February 2003, Mr. Kitano reported no change in the quality and location of his shoulder pain. In the last office visit of March 2003, his knee and shoulder pain had somewhat diminished; the right shoulder pain was at the level of 4 to 5.

Due to Mr. Kitano's shoulder pain, and in the absence of a specific etiology, Dr. Hager diagnosed bilateral shoulder "derangement." Although he initially believed Mr. Kitano may have post-traumatic osteoarthritis in his shoulder, he later withdrew that diagnosis upon review

[34]In Dr. Hager's opinion a pain level of five is discomfort that is not relieved by aspirin.

of radiographic evidence. At the same time, he suspects arthritis and tendonitis may be present in both shoulders. Dr. Hager believes that in 1990 Mr. Kitano did not have a pre-existing right shoulder joint condition. Instead, Mr. Kitano suffered an overuse injury to his right shoulder in 1990. In light of the 2002 examination, Dr. Hager believes that over the course of the following years, Mr. Kitano suffered a cumulative injury to his right shoulder. Noting the right shoulder has "gotten worse over time," Dr. Hager stated that if Mr. Kitano suffered a derangement in the right shoulder that was never properly evaluated, then over time, through repetitive use, it would get worse, "possibly creating an arthritic component."

When Mr. Kitano saw Dr. Okamura in July 2002, he told the physician that in 1990 he hurt both shoulders. Mr. Kitano complained about bilateral knee and shoulder pain. Upon examination, Dr. Okamura found some limits in the neck range of motion. Both shoulders were tender; the tenderness was greater on the left side. Due to physical examination of the left side, Dr. Okamura also suspected a torn rotator cuff. The shoulder x-rays indicated some degenerative arthritis in the shoulder joints, with possible impingement. A CT scan was negative for bony abnormalities in the shoulders but showed degenerative changes in the upper thoracic spine. Dr. Okamura diagnosed bilateral shoulders tendonitis, underlying arthritis, and "possible" left rotator cuff tear. Since Mr. Kitano had injured his shoulders in 1990, Dr. Okamura believed his present shoulder condition was related to those injuries and that Mr. Kitano had suffered a cumulative injury to his right shoulder.

In light of Mr. Kitano's job description, Dr. Okamura believes Mr. Kitano is not able to return to work because the lifting and overhead work would either cause more pain in his shoulders or aggravate the underlying shoulder arthritis and tendonitis. Such work may also adversely affect the possible rotator cuff tear.

Prior to examining Mr. Kitano, Dr. Smith reviewed his medical record and associated objective medical tests from 1990, 2000, 2001, and 2002. Upon physical examination, Mr. Kitano presented complaints of bilateral shoulder and knee pain. Mr. Kitano indicated he experienced a flare-up of shoulder pain in May 2002. However, the objective medical evidence did not support the pain complaints. Upon examination, Dr. Smith recorded subjective tenderness at the shoulder tips. However, Dr. Smith did not feel any crepitation and he found no weakness in the shoulders. During the movement evaluation, Mr. Kitano's range of motion was guarded and limited. That finding was inconsistent with Dr. Smith's observation of Mr. Kitano's shoulder movements during unguarded periods prior to the exam. He also noted that Mr. Kitano's shoulder presentation seemed inconsistent with the videotape of Mr. Kitano lifting and carrying a large frame. Dr. Smith did not find evidence of rotator cuff damage. As a result, Dr. Smith questioned the accuracy of Mr. Kitano's pain presentation and believed he was malingering.

In the shoulder x-rays, Dr. Smith observed degenerative arthritis in Mr. Kitano's shoulder joints and a curved acromion in both shoulders, which might cause impingement syndrome. The shoulder abnormalities developed gradually, pre-existed his May 2002 complaints, and are not work-related. Dr. Smith also believed Mr. Kitano's work did not unusually accelerate or worsen these conditions. Additionally, Dr. Smith found no evidence that Mr. Kitano's present shoulder problems were related to the degenerative C5-6 disc problem discovered in 1990. Mr. Kitano

struggled with age-related shoulder arthritis and impingement syndrome due to a bony abnormality. Although his shoulder arthritis and bony abnormality were not caused by work, his condition could have been possibly aggravated by his employment tasks. Considering the nature of his golf cart attendant job, Mr. Kitano is capable of returning to work.

Discussion

With the previous findings about the 1990 shoulder problem in mind, I return to Mr. Kitano's May 2002 cumulative injury shoulder claim which includes a recurrence of right shoulder pain. Once again, the first step in the adjudication process requires a determination whether Mr. Kitano suffered an injury to his right shoulder in May 2002. Dr. Hager and Dr. Okamura opined that something has gone wrong with Mr. Kitano's right shoulder. Dr. Smith disagrees. In resolving this dispute in medical opinion, I must assess relative probative weight based on three factors, documentation, reasoning, and the Benefits Review Board's standard on subjective pain as an injury.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. In light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

The third factor relates to whether a physician's opinion is consistent with the BRB's determination of subjective pain as an injury. As noted before, *credible* complaints of subjective symptoms and pain, standing alone, may be sufficient to establish an injury under the Act. *Sylvester v. Bethlemhem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom., Sylvester v. Director,* OWCP, 681 F.2d 359 (5th Cir. 1982).

With these factors in mind, on the issue of presence of an injury, or whether something is wrong with Mr. Kitano's right shoulder, I conclude that the opinions of Dr. Hager and Dr. Okamura are better reasoned and more consistent with the medical evidence than Dr. Smith's assessment. Significantly, while I share Dr. Smith's concerns about the accuracy of Mr. Kitano's pain level complaints, some *objective* evidence of a right shoulder dysfunction is present in the

form of an x-ray indicating shoulder joint arthritis. Additionally, even setting aside the pain level reports, Dr. Hager and Dr. Okamura found similar and consistent range of motion limitations with Mr. Kitano's right shoulder.[35]

Next, turning to the causation adjudication process, Mr. Kitano is able to raise the Section 20 (a) presumption of causation. Based on clinical examinations, shoulder x-rays, and the opinions of Dr. Hager and Dr. Okamura, Mr. Kitano has demonstrated that something has gone wrong with his right shoulder. Additionally, over the course of years as a golf cart attendant, he has engaged in repetitive overhead work and shoulder-level lifting that approached his physical limitations established after the 1990 aggravation of his pre-existing degenerative disc disease. These activities could have caused cumulative injury to his right shoulder.

Once again, however, in the form of Dr. Smith's medical opinion, the Employer has successfully rebutted the causation presumption. As a result, based on the preponderance of evidence, I must determine the exact nature of Mr. Kitano's right shoulder dysfunction or injury and whether that condition is related to his employment. That analysis requires that I resolve the conflict between the near-consensus of Dr. Hager and Dr. Okamura and Dr. Smith's contrary view and sort through the medical record which presents three possible mechanisms for a right shoulder injury in June 2002: recurrence of his 1990 right shoulder injury, aggravation of Mr. Kitano's pre-existing C5-6 cervical disc disease, and aggravation of shoulder joint arthritis.

Recurrence of 1990 Right Shoulder Injury

According to Dr. Hager, Mr. Kitano has suffered a right shoulder "derangement" associated with his 1990 right shoulder injury. Specifically, Dr. Hager believes over the course of years Mr. Kitano has suffered a cumulative injury to his right shoulder due to a worsening of Mr. Kitano's untreated 1990 right shoulder injury.

That diagnosis had little probative value due to a significant documentation deficiency. Dr. Hager based his diagnosis in part on his belief that Mr. Kitano suffered an overuse injury to his right shoulder in 1990. However, the sole source of his information about the 1990 incident was Mr. Kitano's recollection of the events. Notably, in concluding Mr. Kitano had a right shoulder derangement, Dr. Hager did not review the medical records relating to Mr. Kitano's right shoulder problem in 1990. As previously discussed, based on my review of the significant medical documentation from that period, I have concluded that Mr. Kitano's intense heavy labor in 1990 aggravated his pre-existing degenerative cervical disc condition and cervical radiculopathy, which manifested itself as right shoulder and arm pain. At the hearing, when confronted with the 1990 diagnosis of C5-6 degenerative disc disease, Dr. Hager indicated he had no basis to disagree with that assessment. He also did not dispute a notation from that period indicating Mr. Kitano's condition had improved with physical therapy. Further, he acknowledged that radiating cervical pain may be mistaken for right shoulder pain.

[35]Dr. Smith stated he was unable to accurately determine the loss of range of motion, if any, in Mr. Kitano's shoulders due to his guarded movements.

According to Dr. Okamura, Mr. Kitano suffered a shoulder injury in 1990; his work activities over the course of the next decade cumulatively worsened that shoulder injury; and, Mr. Kitano's condition in June 2002 is due in part to that cumulative injury.

Dr. Okamura's diagnosis of Mr. Kitano's right shoulder condition and its relationship to work also has a documentary shortfall because he relied solely on Mr. Kitano's recollection about the 1990 shoulder injury and did not closely review the medical record concerning his condition in 1990. This deficiency is significant because Dr. Okamura used an injury to the right shoulder in 1990 as the foundation for his diagnosis. Dr. Okamura incorrectly believed Mr. Kitano injured his shoulder in 1990 and did not know the actual issue with Mr. Kitano's right shoulder in 1990 was degenerative disc disease at C5-6 with right side cervical radiculopathty. In his deposition, Dr. Okamura acknowledged that the absence of a full medical record review might undermine his opinion. I agree.

Dr. Okamura's opinion also loses probative value due to a reasoning concern. Dr. Okamura stated Mr. Kitano's employment as a golf course attendant would aggravate his pre-existing 1990-related shoulder injury or increase its symptoms. However, he based that conclusion on Mr. Kitano working a full 40 hour work week. In reality, Mr. Kitano was working part-time, just a little over half a full work week. In fact, when Dr. Okamura first examined Mr. Kitano, he was aware that Mr. Kitano was only working part-time and concluded he could continue with that level of work.

As noted before, Dr. Smith questions whether any injury exists at all and thus his assessment on whether the present injury has any relationship to the events of 1990 also has diminished value. Nevertheless, Dr. Smith's assessment is noteworthy in one regard on this issue. In terms of documentation, Dr. Smith conducted an extensive review of Mr. Kitano's medical records. In stark contrast to Dr. Hager and Dr. Okamura, Dr. Smith was exceptionally well-informed about the medical findings associated with Mr. Kitano's right shoulder problem in 1990. In particular, he knew Mr. Kitano had a pre-existing C5-6 cervical degenerative disc condition and right-sided radiculopathty.

Since both Dr. Hager and Dr. Okamura had, at best, incomplete documentation and very inaccurate knowledge of Mr. Kitano's right shoulder condition in 1990, I find their reasoning concerning the connection between Mr. Kitano's June 2002 right shoulder problem and his right shoulder pain in 1990 to be insufficient proof that his present condition represents a worsening of a 1990 injury to his right shoulder.

Aggravation of Pre-existing Cervical Disc Disease and Radiculopathty

Previously, I determined that the 1990 incident involved work-related aggravation of Mr. Kitano's C5-6 degenerative disc disease and cervical radiculopathy, which eventually resolved. Based on the medical evidence in this case, the possibility exists that, in a manner somewhat similar to 1990, the repetitive nature of Mr. Kitano's work as a golf cart attendant once again aggravated his pre-existing cervical disc disease and radiculopathty. While such a possibility exists, no physician in this case has presented that causation diagnosis. In fact, the only physician who was fully aware of the C5-6 degenerative disc disease, Dr. Smith, did not believe

such aggravation occurred. Due to their unfamiliarity with the circumstance of Mr. Kitano's 1990 right shoulder injury, neither Dr. Hager nor Dr. Okamura addressed or considered whether aggravation of the C5-6 degenerative disc and right side cervical radiculopathy was the cause of Mr. Kitano's presenting right shoulder pain in June 2002. Consequently, the record evidence fails to establish that Mr. Kitano's present shoulder condition represents a work-related aggravation of his degenerative disc disease.

Aggravation of Right Shoulder Joint Arthritis[36]

As noted by Dr. Okamura and Dr. Smith, the shoulder x-rays disclose arthritis in Mr. Kitano's shoulder joints. In terms of aggravation or acceleration of this shoulder joint arthritis, Dr. Hager touched on the issue by making a conclusory comment about Mr. Kitano's work activities. He opined that the nature and extent of the current pain and pathology of Mr. Kitano's problems were related to his work activities. He also believed Mr. Kitano's symptoms were consistent with shoulder arthritis.

Dr. Okamura believed Mr. Kitano's work as a golf course attendant could accelerate and aggravate his underlying shoulder arthritis. Dr. Smith didn't necessarily disagree; he acknowledged Mr. Kitano's golf course work may have temporarily aggravated his pre-existing shoulder arthritis.

Upon evaluating these opinions, I find the equivocal nature of all three opinions diminishes their probative value in establishing that Mr. Kitano's June 2002 right shoulder injury is due to a work-related aggravation of shoulder joint arthritis. Although shoulder x-rays showed the presence of arthritis in Mr. Kitano's shoulder joints, none of the physicians diagnosed the severity of the condition and as Dr. Hager observed, the shoulder CT scan was negative. Consequently, in determining the degree of any work-related aggravation, the principle diagnostic tool was Mr. Kitano's clinical presentation in terms of subjective interpretations of his pain levels and his tenderness responses to their physical examinations. Unfortunately, for the reasons set out below, I have little confidence in the accuracy of Mr. Kitano's reports of shoulder pain levels.

Based on his examination, review of the medical record, and review of the surveillance tape, Dr. Smith raised significant concerns about Mr. Kitano's pain accuracy. Certainly, Dr. Smith tainted his in-depth documentation foundation with admitted bias concerning individuals who claim total disability based on Dr. Hager's evaluations. Thus, I hesitate to give significant probative weight to his reasoning and final conclusions. At the same time, the record contains no direct evidence that Dr. Smith's personal feelings about our "nation of victims" and other physicians in this case adversely affected the objectivity of his clinical observations. Additionally, many of Dr. Smith's reported observations are more consistent with other independent evidence in the record. In particular, concerning the intensity and accuracy of Mr.

[36]None of the physicians definitively identified Mr. Kitano's work as the cause of his right shoulder joint arthritis. At one point, Dr. Hager suggested Mr. Kitano might have post-traumatic arthritis in his shoulders. However, he later dismissed that diagnosis after he reviewed the negative CT scan findings. Neither Dr. Okamura nor Dr. Smith attributed the presence of arthritis in Mr. Kitano's shoulder joints to his work.

Kitano's shoulder pain complaints, the surveillance video supports Dr. Smith's questioning of the pain levels Mr. Kitano reported to Dr. Hager and Dr. Okamura.

When Mr. Kitano presented to Dr. Hager in May 2002 and through at least February 2003, he stated his left shoulder pain level was 9. According to Dr. Hager, a pain level of 8 indicates very severe pain that would incapacitate an individual and require pain medication. Yet, during this eleven month period of level 9 shoulder pain, an August 2002 videotape shows Mr. Kitano placing a large wooden frame with cement block footings into the bed of truck and later lifting the frame from the truck and carrying it. He accomplishes all these actions without any observable sign of pain or difficulty. A few days later, Mr. Kitano spends a morning clearing debris out of a second story building. Neither his shoulders nor knees appear adversely affected by this extended labor which appears to be somewhat physical considering Mr. Kitano's drenched t-shirt. I find such activities remarkably inconsistent with Mr. Kitano's reported shoulder pain levels during this period, especially considering that he admitted he did not take the pain medication prescribed by Dr. Hager.

I have considered that almost all of the 90 hours of surveillance demonstrated Mr. Kitano did not engage in many outside physical activities, which is consistent with his statement that he mostly stays home and does nothing. I also note that Dr. Hager did not alter his assessment after reviewing the August 2002 video apparently because he believed the wood frame was within Mr. Kitano's lifting limits.[37]

However, on the occasions when Mr. Kitano did come outside, the videotaped physical activities noted above demonstrate that in unguarded movements, Mr. Kitano was capable of using his shoulders to reach, lift, and carry a large frame and to make multiple trips disposing trash. Regardless of the weight of frame or the items of trash, Dr. Hager's reaction to the video is not convincing because he did not address the stark incongruity between his clinic notes of Mr. Kitano's exceptionally high pain levels and his unencumbered, fluid, and normal-looking physical presentation in the videotape. In the video, I observed Mr. Kitano accomplish numerous and varied physically rigorous activities involving his shoulders and knees without any demonstrable evidence of discomfort or pain, let alone the severe to nearly unbearable extremely severe, incapacitating pain, that he reported to the examining physicians and presented at the hearing. Consequently, I have diminished confidence in the accuracy of Mr. Kitano's hearing testimony in regards to his pain levels and the intensity of his pain documented by Dr. Hager and Dr. Okamura based on his clinical presentations.

Finally, I note that proof of work-related aggravation of shoulder joint arthritis is further undermined by Mr. Kitano's own recollection of how work affected his right shoulder. According to Mr. Kitano, although after 1990 his right shoulder pain never went away, it essentially remained the same over the course of his work and was not disabling by itself. From 1990 through his presentation to Dr. Hager in May 2002, the nature of the pain in his right shoulder did not change. He specifically testified that his job, including the overhead work, did not aggravate his right shoulder. As discussed in greater detail in regards to the left shoulder

[37]Dr. Okamura did not see the videotape.

injury claim, some entries from his medical record from 1993 to 2000 offer corroborating support for this recollection of the stable condition of his right shoulder.

In summary, due to my lack of confidence in Mr. Kitano's clinical presentations of his pain levels, I see little credible support for the physicians' opinion in regards to the aggravation of Mr. Kitano's underlying right shoulder arthritis. Thus, I conclude Mr. Kitano's June 2002 right shoulder condition does not represent a work-related aggravation or acceleration of his pre-existing shoulder joint arthritis. In the absence of any other probative evidence, it appears Mr. Kitano is simply struggling with the aches associated with age-related shoulder joint arthritis.

Conclusion

Ultimately, for the reasons discussed above, I find that Mr. Kitano has failed to prove that his right shoulder problem in June 2002 was caused by his employment with Marine MWR. His right shoulder condition is unrelated to the 1990 aggravated degenerative cervical disc disease condition. Further, the record is insufficient to establish Mr. Kitano's employment in May 2002 aggravated his pre-existing C5-6 cervical disc disease and radiculopathty. And, the evidence does not support a finding that his work as a golf cart attendant caused, aggravated, or accelerated his right shoulder joint arthritis. Accordingly, Mr. Kitano has failed to prove that his May 2002 right shoulder problem is related to his employment and his claim for disability compensation and medical benefits for the right shoulder injury must be denied.[38]

B. Left Shoulder/Bilateral Cumulative Shoulder Injury

Obviously, the other half of Mr. Kitano's claimed June 2002 bilateral cumulative shoulder injury involves his left shoulder. In response to the claimed left shoulder/bilateral cumulative shoulder injury, the Employer contests causation, nature and extent of disability, and medical benefits.

Issue No. 1 - Causation

In regards to the left shoulder, the medical record raises the possibility of one specific injury unique to the left shoulder and a generalized left shoulder injury.

The prospect of a specific injury was raised by Dr. Okamura. During his evaluation of Mr. Kitano, Dr. Okamura developed a "working" diagnosis of a left shoulder rotator cuff tear/superior labral tear.[39] Based on his examination of the left shoulder and noted tenderness in the rotator cuff area, Dr. Okamura suspects Mr. Kitano may have a tear. Until he is able to obtain additional tests to confirm his suspicion, Dr. Okamura is only suggesting the possibility of a rotator cuff tear.

[38]Since Mr. Kitano's right shoulder condition is not work-related, I do not need to address the nature and extent of any resulting disability, disability compensation, and medical benefits.

[39]In the initial July 2002 examination, Dr. Okamura suggested bilateral shoulder rotator cuff tears. However, by the time of his April 2003 examination, his focus was on the left shoulder in terms of rotator cuff/superior labral tear.

Dr. Smith examined the same area, reported the absence of any crepitation[40] or weakness and indicated Mr. Kitano had no pain complaints in that area. As a result, he disagrees with Dr. Okamura and finds no evidence of a rotator cuff tear and no necessity for additional tests. Dr. Hager did not render a separate opinion on a rotator cuff tear; he simply mentioned that Dr. Okamura had diagnosed that possibility.

In setting the respective probative values of these divergent opinions, I first note that Dr. Okamura's diagnosis of a possible rotator cuff tear is equivocal which diminishes the probative value of his diagnosis. Next, Mr. Kitano's report of tenderness and weakness in the rotator cuff area is apparently a principle factor in Dr. Okamura's "working" diagnosis. However, Mr. Kitano's pain reporting is already suspect. Additionally, for the left shoulder rotator cuff tear, his reported sensitivity is also inconsistent because he did not report to Dr. Smith any pain in the same area.[41] Additionally, in his examination of the left shoulder, Dr. Hager apparently did not find any symptoms consistent with a rotator cuff tear since he did not diagnose that injury in any of his treatment notes. This inconsistency in clinical presentations reduces the credibility of the foundation upon which Dr. Okamura rests his diagnosis and further adversely affects the probative value of his opinion. Finally, and in contrast, Dr. Smith's assessment is unequivocal. He expressed certainty based on the absence of any reported pain in the rotator cuff location and his objective finding of no crepitation in the rotator cuff area. Thus, on this issue, Dr. Smith's opinion is more probative.

Consequently, due to the equivocal nature of Dr. Okamura's diagnosis, the absence of a similar diagnosis by Dr. Hager, the inconsistent rotator cuff area pain reports by Mr. Kitano, and Dr. Smith's observations, I conclude Mr. Kitano has failed to prove that he has a left rotator cuff injury in his left shoulder.

In terms of a generalized injury to his left shoulder, I reach the same conclusion that I did concerning the right shoulder. The shoulder x-ray indicates the presence of arthritis in Mr. Kitano's shoulders and both Dr. Hager and Dr. Okamura found consistent range of motion problems with the left shoulder. Accordingly, I conclude something has gone wrong with Mr. Kitano's left shoulder by May 2002.

The same initial steps of the causation adjudication discussed under the right shoulder injury are also applicable for the left shoulder injury. Mr. Kitano is able to invoke the Section 20 (a) causation presumption and the Employer is able to rebut the presumption. So, I return to examining whether the preponderance of the more probative evidence establishes that Mr. Kitano's left shoulder injury was caused by his employment.

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[40]A sound made by rubbing together the ends of a fractured bone. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 391 (28th ed. 1994).

[41]Again, while Dr. Smith's noted bias has been identified, his witness demeanor was straight forward and I find no evidence that his bias has caused him to fabricate his clinical observations. In other words, I believe his objective examination results are trustworthy.

Background and Medical Opinion

Following the 1990 aggravation of his C5-6 degenerative disc disease, Mr. Kitano maintains he continued to experience some pain in his right shoulder. He was right-handed and favored the right shoulder, thereby putting more stress on the left shoulder. According to Mr. Kitano, as he nursed his right shoulder, the left shoulder began to hurt and gradually worsened.

In a 1993 medical history, the only health problem Mr. Kitano reported was a "ruptured disc." Similarly, in a 1995 pre-operative survey, Mr. Kitano only reported neck and back pain. In February 2000, Dr. Lum treated Mr. Kitano's left shoulder pain, which he reported as being intermittent for the past several years. Dr. Lum noted some decreased range of motion and tenderness in the left shoulder. The physician diagnosed bursitis. As previously summarized between 1990 and the summer of 2002, Mr. Kitano continued to work. By the summer of 2002, Mr. Kitano claims he was experiencing significant pain in his left shoulder such that he relied "mostly on my right shoulder now."

In May 2002, based on Mr. Kitano's pain complaints, shoulder tenderness, and reduced range of motion, Dr. Hager diagnosed bilateral shoulder derangement. The pain level in the left shoulder was 9. Eventually, the physician concluded this condition was related to Mr. Kitano's work at the golf course. He explained that over time, Mr. Kitano's right shoulder injury worsened, which caused him to favor his right shoulder thereby placing a greater load on the left shoulder. Consequently, both right and left shoulder conditions are related to his employment. Due in part to his worsening shoulder pain, Dr. Hager took him off his job in July 2002.

Dr. Okamura used three components, shoulder pain complaints, tenderness, and limited range of motion, to diagnose a cumulative injury to both shoulders. In determining the etiology of the bilateral shoulder condition, Dr. Okamura referenced Mr. Kitano's 1990 injury to both shoulders and concluded his present right and left shoulder conditions were related to the 1990 injuries. Since radiographic evidence established the presence of arthritis in Mr. Kitano's left shoulder joints, Dr. Okamura also suggested that his work activities over a period of time could have cumulatively aggravated that condition.

When Dr. Smith examined Mr. Kitano's left shoulder area, he noted tenderness in the left shoulder acromion area and supraspinatus tendon. Upon review of the medical evidence, including shoulder x-rays, he concluded Mr. Kitano's left shoulder problems were related to a developmental bone abnormality, involving the curvature of the acromion. The bony structure was not caused by Mr. Kitano's employment. Additionally, due to the inconsistencies between Mr. Kitano's clinical pain complaints with his unguarded shoulder movements noted in his office and on the surveillance video, Dr. Smith expressed doubts about the actual extent of Mr. Kitano's shoulder pain.

Discussion

Consistent with the analysis concerning the right shoulder injury, the record raises the possibility of three work-related causes for Mr. Kitano's left shoulder injury.

Left Shoulder Injury Due to Recurrence of Right Shoulder Injury

In evaluating the medical evidence in regards to Mr. Kitano's left shoulder, I first highlight the contrast between his description to Dr. Hager, Dr. Okamura and Dr. Smith about the development of his left shoulder pain with the medical record entries from 1993, 1995, and 2000. Mr. Kitano reported to the physicians that from about 1992 through 2002, he experienced persistent pain in his right shoulder, which led to more stressful use of his left shoulder, and caused the gradual development of severe left shoulder pain. Yet, in 1993 the only health concern Mr. Kitano listed was a ruptured disc; he did not mention anything about his shoulders. In 1995, the only pain Mr. Kitano reported was located in his neck and back; again no mention of shoulder pain. Finally, when he presented to Dr. Lum in 2000 for left shoulder pain, there was no notation about Mr. Kitano mentioning any right shoulder pain or suggesting it may have caused the left shoulder problem. Mr. Kitano also told Dr. Lum his left shoulder pain was intermittent, which seems to differ from his description to the other three doctors of gradually worsening shoulder pain. These inconsistencies further erode my confidence in the accuracy of the Mr. Kitano's shoulder pain reports.

For a familiar documentation reason, Dr. Hager's conclusion that Mr. Kitano's left shoulder injury is related to his employment and involves a cumulative injury has diminished probative value. The physician links the left shoulder problem to the gradually worsening condition of the right shoulder which was injured in 1990. However, that causation linkage fails because it rests on inaccurate documentation about the 1990 right shoulder problem – Mr. Kitano's personal recollection. As discussed in considering the right shoulder claim, the right shoulder injury upon which Dr. Hager bases his causation and cumulative injury opinion did not occur. And, the medical evidence from 1992 indicates the aggravation of Mr. Kitano's cervical disc disease had been resolved by that time.

Dr. Okamura's causation and cumulative injury findings in regards to the left shoulder injury also have little probative value because he considered the present condition to be related to the injury to both shoulders Mr. Kitano suffered in 1990. Mr. Kitano did not injure both shoulders in 1990. In fact, only his right shoulder and arm were affected by the C5-6 disc disease and right side cervical radiculopathy. In 1990, Mr. Kitano reported no problems with his left shoulder or arm.

Since Dr. Smith did not find any connection between the present shoulder problems and 1990, the record contains no probative medical opinion to support the causation theories linking Mr. Kitano's present left shoulder problem to the 1990 right shoulder problem. Thus, I conclude Mr. Kitano's left shoulder problem or dysfunction is not related to the 1990 aggravation of his degenerative disc disease.

Aggravation of Pre-existing Cervical Disc Disease and Radiculopathty

Likewise, the record contains no medical assessment that a present aggravation of Mr. Kitano's pre-existing C5-6 cervical disc disease has caused his left shoulder pain. The

connection is even more nebulous considering the 1990 cervical radiculopathty occurred on Mr. Kitano's right side.

Aggravation of Left Shoulder Joint Arthritis[42]

In considering whether Mr. Kitano's golf cart attendant work aggravated his left shoulder joint arthritis, I reach the same conclusion that I did concerning the right shoulder. Mr. Kitano's pain complaints were the major diagnostic tool available to the treating physicians. Clinically, Mr. Kitano presented with exceptionally elevated left shoulder pain levels. Yet, his observed unguarded shoulder movements in the videotape are inconsistent with that presentation. Due to this demonstrated incongruity, his statements about the pain level in his left shoulder are exceptionally unreliable, which in turn diminishes the probative value of the opinions of Dr. Okamura and Dr. Smith about aggravation of the left shoulder joint arthritis. As a result, I find insufficient probative evidence to support a finding that Mr. Kitano's part-time work as a golf cart attendant has aggravated or accelerated his left shoulder joint arthritis.

Conclusion

In summary, for the reasons noted above, while arthritis is present in his left shoulder joints, I find Mr. Kitano's left shoulder condition is not related to the 1990 aggravation injury or his pre-existing cervical disc disease. Additionally, since the physicians relied on the accuracy of Mr. Kitano's shoulder pain presentations, which are not credible, insufficient evidence exists to conclude Mr. Kitano's golf course employment caused, aggravated, or accelerated his left shoulder joint arthritis. Accordingly, Mr. Kitano has failed to prove that his left shoulder problem is related to his employment or due to a cumulative injury. Consequently, his claim for disability compensation and medical treatment for the left shoulder problem must be denied.[43] Further, having determined the condition of neither shoulder is work-related, Mr. Kitano's claim for a cumulative, bilateral shoulder injury must be denied.

C. Right Knee Injury/Cumulative Bilateral Knee Injury

As should be readily apparent by now, Mr. Kitano's case contains many parallels. Due to a June 18, 2000 accident, Mr. Kitano claims to have suffered an injury to his right knee which continues to cause pain and has again become totally disabling. Additionally, this continuing right knee condition has caused problems in his left knee. Together, these injuries form the basis of Mr. Kitano's cumulative bilateral knee injury claim. Thus, the analysis is separated into inquiries about the right and left knee.

The Employer asserts that any work-related injury to Mr. Kitano's right knee from the June 18, 2000 accident has been resolved; and, any remaining discomfort relates to pre-existing arthritis in his knees. Additionally, the condition of his right knee does not preclude his

[42]Again, no physician suggested Mr. Kitano's work caused the shoulder joint arthritis.

[43]Since Mr. Kitano's left shoulder condition is not work-related, I do not need to address the nature and extent of any resulting disability, disability compensation, and medical benefits.

employment as a part-time golf cart attendant. In other words, the Employer contests the nature and extent of disability and Mr. Kitano's entitlement to additional disability compensation and medical benefits.

Issue No. 1 – Nature and Extent of Disability, and Disability Compensation

Under the Act, a longshoreman's inability to work due to a work-related injury is addressed in terms of the nature of the disability (permanent or temporary) and extent of the disability (total or partial). In a claim for disability compensation, the claimant has the burden of proving, through the preponderance of the evidence, both the nature and extent of disability. *Trask v. Lockheed Shipbuilding & Constr. Co*., 17 BRBS 56, 59 (1985).

To place the issues of nature and extent of any disability associated with the right knee injury on June 18, 2000 into perspective, I must preliminarily examine the circumstances of the June 18, 2000 accident and determine the characteristics of Mr. Kitano's right knee injury.

June 18, 2000 Accident

Over the course of his employment with the Marine Corps MWR, until June 18, 2000, Mr. Kitano did not report any injuries or incidents involving either knee. Similarly, a review of his medical record fails to disclose any injuries to, or complaints about, either knee. In fact, just a little over a year before Mr. Kitano twisted his right knee at work, he was able to successfully complete a treadmill stress test without any notation about knee problems on April 21, 1999.

On June 18, 2000, Mr. Kitano was working at the Marine Corps golf course. Part of his duties involved washing golf balls collected from the driving range. As he explained, during that process, dirt and rock debris fell to the ground around the ball washer. He stepped on one of those rocks and twisted his right leg and knee.

Although Dr. Smith had some reservations about any work-related accident, the parties have stipulated that Mr. Kitano was involved in an accident at work on June 18, 2000. While Mr. Kitano's accuracy in reporting his pain levels is suspect, I believe his recollection about the circumstances of the accident on June 18, 2000 based on the detail associated with his description. That is, had the description of the accident been fabricated, there would have been no need to include details about the job he was performing at the time and fallen debris from the ball washer. He could simply have stated he tripped at work. Additionally, all of the physicians who treated Mr. Kitano's right knee after June 18, 2000 did not express any reservation about his accident description. Accordingly, I find on June 18, 2000, Mr. Kitano twisted his right knee during and in the course of his employment with the Marine Corp MWR.

Injury Characteristics

To assess the damage the June 18, 2000 accident caused to Mr. Kitano's right knee and establish the injury's characteristics, I must consider and evaluate multiple, conflicting medical opinions.

On the same day he twisted his right knee, June 18, 2000, after Mr. Kitano left work, an unnamed physician examined Mr. Kitano's knee. Although no swelling was evident, the doctor annotated Mr. Kitano's pain in the medial aspect of the right knee and his difficulty walking. The physician diagnosed right knee sprain.

The next day, June 19, 2000, four x-rays of the right knee revealed mild narrowing of the medial joint compartment and some pointing of the tibial spines. However, no prominent degenerative changes were noted.

About eleven days later, Dr. Sandor, a treating physician, reported slight effusion with warmth in the right knee and tenderness along the medial collateral ligament. He diagnosed medial collateral ligament strain of the right knee. Over the course of the next several months, Mr. Kitano continued to have a problem with his right knee and occasionally experienced sharp pain in the medial tibia area. At that time, Dr. Sandor diagnosed right knee bursitis following a sprain. As Mr. Kitano's specific pain failed to resolve by October 2000, Dr. Sandor referred him to an orthopedic surgeon the next month to rule out the possibility of a torn meniscus. A year later, on October 4, 2001, when Mr. Kitano returned after his treatment with Dr. Van Meter, Dr. Sandor reviewed the medical record, noted Dr. Van Meter's treatment, and recorded Mr. Kitano's continued right knee pain. Dr. Sandor diagnosed DJD (degenerative joint disease) with aggravation secondary to a meniscus tear. He restricted Mr. Kitano from running, jumping, and lifting more than 25 pounds. Mr. Kitano was permitted to occasionally kneel, squat, and climb. Dr. Sandor concluded Mr. Kitano had reached MMI. In January 2002, after another examination, Dr. Sandor made the work restrictions and limitations permanent and diagnosed post-trauma arthritis. In June 2002, Mr. Kitano reported some pain relief with new medication. According to Dr. Sandor, Mr. Kitano indicated that he continued to tolerate his part-time work well. In October 2002, Mr. Kitano reported continued right knee pain.

When the orthopedic surgeon, Dr. Van Meter, examined Mr. Kitano in December 2000, he found "positive medial joint line tenderness." An arthrogram administered the same month established the presence of joint effusion and possible damage to the medial meniscus. In the February 2001 arthroscopic procedure, Dr. Van Meter discovered two tears in the right knee medial meniscus (one in the posterior section and one in the middle two-thirds area). Dr. Van Meter then excised the tears. He also observed grade IV arthritis in other portions of the knee. After the procedure, he diagnosed meniscus tear and arthritis. Over the course of the next months of care, Dr. Van Meter treated the meniscus tear as an industrial accident. Dr. Van Meter diagnosed meniscus tear and DJD. Following physical therapy, Dr. Van Meter noted Mr. Kitano's continued right knee pain. Dr. Van Meter believed the arthritis pre-existed the meniscus tear and was the source of his present right knee pain. Effective July 30, 2001, Mr. Van Meter released Mr. Kitano for return to work with a weight lifting limitation. On August 30 and September 26, 2001, Dr. Van Meter concluded Mr. Kitano had reached maximum medical improvement in regards to his meniscus tear. According to Dr. Van Meter, Mr. Kitano's continued struggle with knee pain was related to his "pre-existing underlying arthritis condition."

After Dr. Scarpino examined the right knee the following year, in February 2002, he concurred with Dr. Van Meter's assessment that Mr. Kitano had reached maximum medical improvement and recovered from the meniscus tear. According to Dr. Scarpino, in October

2002, the remaining right knee symptoms were related to the underlying osteoarthritis and not the June 18, 2000 work injury.

In May 2002, Mr. Kitano presented to Dr. Hager with right knee pain, particularly in the medial meniscus compartment area, at a pain level of 8. Mr. Kitano informed the physician that he had twisted his knee at work in 2000 and eventually had knee surgery; however the pain persisted and the knee had not returned to normal. Mr. Kitano had not experienced any problems prior to the accident. Dr. Hager found the right knee "diffusely tender" with full range of motion and strength. He diagnosed knee derangement. Dr. Hager was aware of a history of osteoarthritis in the right knee. Based on Mr. Kitano's statements, Dr. Hager believes his right knee worsened after his return to work in 2000. A July 2002 CT scan indicated "moderate degenerative changes in medial compartment." In February 2003, Mr. Kitano had 9 level pain in the right knee; in March 2003 the pain had improved to 6-7. Dr. Hager diagnosed post-traumatic osteoarthritis in the right knee with meniscus tear. Because the diagnostic tests were conducted several months after the accident, and arthritis had plenty of time to develop in the interim, Dr. Hager does not believe Mr. Kitano had arthritis in his knees prior to the accident. Instead, he attributes the present underlying arthritis to the meniscus tear. His present symptoms are related to that arthritis. Dr. Hager stopped Mr. Kitano from working because he was experiencing pain in the left, not right, knee; at the same time, he also believes both knees together are disabling. His assessment on the ability to return to work is based on Mr. Kitano's presentation. Mr. Kitano is totally disabled for his golf cart attendant duties considering its lifting requirements and awkward ergonomics. His disability is temporary until a determination can be made about appropriate repairs to his shoulders and knees. The current discomfort in his right knee is related to the stress of work. Mr. Kitano has a ratable impairment to his right knee. While agreeing with Dr. Van Meter that no further treatment is necessary, pending additional evaluation, Mr. Kitano's right knee has not reached MMI.

When Dr. Okamura examined Mr. Kitano in July 2002, he reported greater pain in his left knee than the right knee. The physician noted the CT scan findings of moderate degenerative changes in right knee medial compartment. He believed the CT scan showed "longstanding" spurring and moderate degenerative changes and diagnosed arthritis. In April 2003, Mr. Kitano reported greater pain in the right knee. According to Dr. Okamura, the right knee surgery only addressed the meniscus tear; it did not treat the underlying arthritis. Dr. Okamura did not review the medical reports associated with the knee surgery. Because he needs additional testing for his knees, Mr. Kitano is not at MMI. In the meantime, Mr. Kitano is temporarily totally disabled due to his knees. If he returned to work, Dr. Okamura would impose squatting and jumping restrictions. When he first examined Mr. Kitano, he thought Mr. Kitano could continue his part-time work. His restrictions relate to full time work.

According to Dr. Smith, Mr. Kitano had pre-existing osteoarthritis, or degenerative joint disease, in the right knee medial compartment that led to a degenerative, rather than traumatic, medial meniscus tear. He believes the June 18, 2000 accident involved a medial collateral ligament sprain. According to Dr. Smith, after the right knee surgery, Mr. Kitano's pain level returned to its pre-operation level. Mr. Kitano's right knee reached MMI on October 4, 2001. Any remaining symptoms are due to his pre-existing arthritic condition. A July 2002 right knee x-ray showed mild narrowing of the medial joint space and a small spur, which is indicative of

osteoarthritis. He also notes that the operative note from the knee surgery included a finding which equates to very longstanding arthritic condition. Both his physical examination of the right knee and observation of the surveillance video led Dr. Smith to conclude Mr. Kitano's knee is within normal limits. Dr. Smith believes Mr. Kitano's pain complaints were questionable. Based on the partial medial meniscetomy, Mr. Kitano has a 2% impairment to the lower extremity, but that impairment is not work-related. Dr. Smith opined Mr. Kitano is capable of returning to work as a part-time golf cart attendant.

Discussion

In light of this medical evidence and applying the causation analysis, I conclude Mr. Kitano is able to invoke the Section 20 (a) presumption that his present right knee condition is work related. The evidence shows Mr. Kitano has a dysfunction in his right knee. On June 18, 2000, Mr. Kitano was involved in an accident at work that could have caused that dysfunction. At the same time, Dr. Smith's opinion that Mr. Kitano's present right knee problem is degenerative rather than traumatic overcomes that presumption. Consequently, I must again review the entire record in regards to Mr. Kitano's right knee.

In rebutting the causation presumption, Dr. Smith asserts that both the right knee medial meniscus tear and arthritis are degenerative in nature. Mr. Kitano merely suffered a medial ligament sprain when he twisted his right knee at work on June 18, 2000. Based on consideration of the entire record, I find Dr. Smith's assessment has a reasoning deficiency, is inconsistent with significant circumstantial evidence and most significantly is overwhelmed by the great preponderance of the medical opinion.

The underlying reasoning of Dr. Smith's opinion is diminished somewhat by close examination of Dr. Van Meter's knee surgery findings. To support his diagnosis of a degenerative meniscus tear, Dr. Smith highlighted Dr. Van Meter's description of a complex tear in the posterior part, which he asserts means the damage to the medial meniscus was due to arthritis. Actually, Dr. Smith reported two tears in the medial meniscus, one in the posterior portion, which Dr. Smith emphasized, and one in the middle two-thirds of the meniscus, which Dr. Smith did not mention.

Further, the circumstantial evidence corroborates a traumatic cause to the meniscus tear. Prior to June 18, 2000, Mr. Kitano had no reported knee problems. On June 18, 2000, he twisted his right knee and presented to a physician that evening with pain in the medial aspect of his right knee. When conservative treatment failed to resolve the medial compartment pain, an arthrogram suggested and arthroscopic surgery confirmed, two tears in the right knee medial meniscus.

Concerning the preponderance of the evidence, as set out in the detailed medical evidence summary, Dr. Sandor, Dr. Van Meter, Dr. Scarpino, Dr. Hager, and Dr. Okamura either directly or indirectly concluded the right knee medial meniscus tear was related to the June 18, 2000 traumatic accident. Their consensus overcomes Dr. Smith's singular contrary opinion in regards to the cause of the right knee medial meniscus tear. Accordingly, I conclude that on June 18, 2000 Mr. Kitano tore the medial meniscus when he twisted his right knee at work.

Having determined that Mr. Kitano's right knee medial meniscus damage was caused by the June 18, 2000 work-related accident, I must next address the nature of the other abnormality present in his right knee, arthritis. Predictably, conflicting medical evidence exists on this issue too.

Some evidence exists to support Dr. Hager's opinion that Mr. Kitano is presently struggling with traumatic-induced osteoarthritis due to the June 18, 2000 accident and meniscus tear. The medical record prior to June 18, 2000 contains no evidence of any right knee problems. The June 19, 2000 right knee x-ray failed to reveal any "prominent" degenerative changes. Several months later, in February 2001, during the arthroscopic surgery procedure, Dr. Van Meter reported several degenerative changes in the right knee and radiographic studies in July 2002 showed moderate degenerative changes.

On the other hand, when Dr. Van Meter described the observed degenerative changes, he did so in terms of longstanding osteoarthritis. Upon completion of his treatment of Mr. Kitano's medial meniscus tear, he indicated that the remaining symptoms related to the underlying pre-existing arthritis. Dr. Sandor, Dr. Scarpino, Dr. Okamura, and Dr. Smith express essentially the same opinion.

In assessing the relative probative weight between the contrasting medical opinions, I consider Dr. Van Meter's assessment to be more probative for three reasons. First, Dr. Van Meter is a board certified orthopedic surgeon while Dr. Hager does not have that specialized expertise. Second, Dr. Van Meter based his conclusion on direct observation of the right knee's condition from within the right knee during the arthroscopic surgery, in contrast to external radiographic studies. Third, Dr. Van Meter is the only physician who actually observed the nature of the arthritis in Mr. Kitano's knee, which gives him an exceptional documentation advantage over Dr. Hager.

Accordingly, based on Dr. Van Meter's more probative opinion, as supported by the clear majority of the physicians to evaluate the right knee, I find that on June 18, 2000, Mr. Kitano had pre-existing osteoarthritis in his right knee. In other words, contrary to Dr. Hager's opinion, the June 18, 2000 accident did not cause the osteoarthritis in Mr. Kitano's right knee.

To complete the assessment of the present condition of Mr. Kitano's right knee, I must further consider the relationship between Mr. Kitano's pre-existing osteoarthritis, his June 18, 2000 work-related accident, and the resulting torn medial meniscus.

Because Dr. Hager believed the right knee arthritis was due to the June 18, 2000 accident and was not pre-existing, his opinion has little probative value on this topic. Additionally, Dr. Okamura did not really discuss the relationship, if any, between the underlying arthritis and medial meniscus tear.

Naturally, the remaining four doctors disagree on the linkage. At the conclusion of his surgical treatment of Mr. Kitano, Dr. Van Meter concluded any continuing symptoms were solely due to his pre-existing osteoarthritis and not related to his work or the accident. Dr.

Scarpino and Dr. Smith essentially concur. On the other hand, Dr. Sandor believed the medial meniscus tear aggravated Mr. Kitano's underlying osteoarthritis.

In resolving this medical dispute and considering relative probative weight, I find that despite their consensus and orthopedic expertise, the conclusions of Dr. Van Meter, Dr. Scarpino and Dr. Smith are not well reasoned on the relationship. Specifically, these doctors did not address the absence of any right knee problems prior to accident-induced medial meniscus tear and Mr. Kitano's post-surgery emergent, and continuing, right knee pain. This reasoning lapse is significant because the pre-existing right knee osteoarthritis was asymptomatic prior to June 18, 2000. Yet, after the accident, corrective knee surgery, and resolution of the medial meniscus problem, Mr. Kitano's right knee pre-existing osteoarthritis had become symptomatic.

In contrast, I give greater probative weight to Dr. Sandor's conclusion because he recognized this change in condition. His opinion that the medial meniscus tear aggravated the pre-existing osteoarthritis represents the best integration of all the medical and work history evidence in the record. Based on Dr. Sandor's more probative opinion, I find: a) that the medial meniscus tear caused by the June 18, 2000 work-place accident aggravated Mr. Kitano's pre-existing right knee osteoarthritis, or degenerative joint disease; and, b) Mr. Kitano's symptoms remaining after he reached MMI for the torn medical meniscus are due to the aggravated osteoarthritis.

Nature

Having determined the characteristics of Mr. Kitano's work-relate right knee injury, I must next address the nature of that injury and associated disability. The nature of a disability may be either temporary or permanent, and reflects an injury's potential for improvement through medical treatment. Although the consequences of a work-related injury may require long term medical treatment, an injured employee reaches maximum medical improvement when his condition has stabilized. *Cherry v. Newport News Shipbuilding & Dry Dock Co*., 8 BRBS 857 (1978). In other words, the nature of the worker's injured condition becomes permanent and the worker has reached maximum medical improvement when the individual has received the maximum benefit of medical treatment such that his condition will not improve. *Trask*, 17 BRBS at 60. Any disability suffered by a claimant prior to MMI is considered temporary in nature. *Berkstresser v. Washington Metropolitan Area Transit Authority*, 16 BRBS 231 (1984). If a claimant has any residual disability after reaching MMI, then the nature of the disability is permanent.

Of the medical opinions that focused on Mr. Kitano's recovery from his right knee injury, Dr. Smith, Dr. Van Meter, and Dr. Scarpino only considered the meniscus tear as the injury and just focused on his recovery from the surgical procedure. As a result, other than establishing that Mr. Kitano's knee had reached MMI by August-September 2001 in terms of the medial meniscus damage, their consensus is not probative on the issue of whether the aggravated osteoarthritis has reached MMI. Only Dr. Sandor, Dr. Hager, and Dr. Okamura considered the nature of Mr. Kitano's continuing right knee problems.

Dr. Sandor, Mr. Kitano's treating physician in regards to the right knee from June 2000 through about the fall of 2002, concurred with Dr. Van Meter's surgical MMI finding on October 4, 2001. In an October 2001 examination, he found Mr. Kitano's right knee to be stable and believed it was ratable for a disability. He imposed permanent work restrictions on Mr. Kitano's golf course attendant work concerning running, jumping, and lifting more than 25 pounds. Other limitations included occasional squatting, kneeling, and climbing. When Mr. Kitano returned in January 2002, he reported the same right knee pain and indicated that he occasionally had to stop walking. Dr. Sandor noted Mr. Kitano hobbled and did not fully extend his right knee when walking. He diagnosed post-traumatic arthritis. He also included another work limitation - standing and walking as tolerated. When Mr. Kitano retuned in March 2002, Dr. Sandor recorded no change in status. After the June 2002 examination, Dr. Sandor indicated that medication seemed to be helping Mr. Kitano and that he was tolerating his part-time work well. In October 2002, Mr. Kitano reported his knee still hurt.

Based on his examination, Dr. Hager believes Mr. Kitano's right knee has not reached MMI because it had not been fully evaluated. Additional diagnostic tests are necessary so Mr. Kitano's problem can be identified and fixed. On July 26, 2002, in response to Mr. Kitano's reported worsening pain levels, Dr. Hager placed him in off duty status. At that time, while Mr. Kitano reported knee and shoulder problems, Dr. Hager stated he would have removed him from work even if he didn't have knee problems. Likewise, if the knees had been his only problem, Dr. Hager would have stopped Mr. Kitano from working. In Dr. Hager's opinion, after Mr. Kitano returned to work following resolution of his knee surgery, his conditioned worsened based on his pain complaints.

On July 11, 2002, Dr. Okamura was introduced to Mr. Kitano who was working part-time as a golf course attendant. Mr. Kitano had pain along the medial aspect of the knee. Due to left knee complaints, he recommended an arthrogram to rule out a meniscus tear in the left knee. However, Dr. Okamura also indicated Mr. Kitano could continue with his part-time work. In April 2003, based on Mr. Kitano's complaints of worsening pain following his return to work after recovery from the knee surgery, Dr. Okamura believes the cumulative trauma of lifting and carrying activities at work are responsible. Dr. Okamura concluded Mr. Kitano's knees were not at MMI because he needed more diagnostic tests. Dr. Okamura considered Mr. Kitano to be temporarily totally disabled due to his knees. If Mr. Kitano returned to work, Dr. Okamura would restrict squatting and jumping and limit lifting, pulling, and pushing.

In attempting to address this conflict between the three physicians on whether Mr. Kitano has reached maximum medical improvement for his right knee, I am struck by the different presentations Mr. Kitano apparently made to Dr. Sandor in comparison with his presenting complaints to Dr. Hager and Dr. Okamura. Specifically, between October 2001 and October 2002, with Dr. Sandor, Mr. Kitano's right knee pain remained the same and stable. In June 2002, he was able to tolerate his part-time work well and the medication was helping. Yet, a month later, before Dr. Hager, Mr. Kitano's pain was so intolerable he had to be removed from work. This seeming inconsistency in pain levels reported to Dr. Sandor and Dr. Hager brings me back to my previous concern about the credibility of Mr. Kitano's pain reports.

Both Dr. Hager and Dr. Okamura are basing their MMI assessments on Mr. Kitano's stated right knee pain levels and the alleged worsening of his pain. However, contemporaneous videotape has created sufficient doubt in my mind as to the accuracy of his pain reporting. In August 2002, Mr. Kitano was able to move a large wooden frame without any apparent interference with a right knee problem. Although the May 2003 videotape shows the hobble and right knee extension problem noted by Dr. Sandor, his knee condition doesn't appear to prevent Mr. Kitano's multiple trips up and down stairs to remove trash. Additionally, as discussed in detail in regards to his shoulder complaints, Mr. Kitano's unguarded physical movements are inconsistent with the high knee pain levels that he reported (level 8 for his right knee in May 2002 into July 2002; and level 6-7 in May 2003). As a result, I give less probative weight to the conclusions of Dr. Hager and Dr. Okamura due to their reliance on uncertain documentation – Mr. Kitano's statements of pain levels.

In comparison, while Mr. Kitano's report of stable pain to Dr. Sandor may also have been inaccurate, his presentation to Dr. Sandor appears to be more consistent with his unguarded, videotaped activities in August 2002. Thus, Dr. Sandor seems to have more reliable documentation. More important, Dr. Sandor was in a unique position as Mr. Kitano's treating physician between June 2000 and the fall of 2002. He saw Mr. Kitano shortly after the June 18, 2000 accident, assessed the condition of his right knee, eventually referred him to an orthopedic specialist, and then once again evaluated Mr. Kitano post-surgery and over a significant period of time after he returned to his part-time work. Based on that long-term contact during the critical phases of the treatment of Mr. Kitano's right knee injury, I conclude Dr. Sandor's assessment on MMI carries the greater probative weight. I also note in terms of treatment for Mr. Kitano's right knee, his right knee has already been evaluated by a CT scan, an arthrogram, and an arthroscope during the treatment of the accident-induced meniscus tear. Those diagnostic tests revealed only two problems, arthritis and torn medical meniscus. Additionally, Dr. Van Meter reported in his February 2002 arthroscopic surgery report that other than the specifically noted defects, all other portions of the right knee were normal. Well aware of the test results, the outcome of the right knee surgery, the reported effectiveness of medication in June 2002, and Mr. Kitano's job tolerance, Dr. Sandor's apparent decision to not pursue other treatment modalities appears reasonable.

Accordingly, based on Dr. Sandor's more probative medical opinion, I conclude Mr. Kitano's right knee injury, consisting of aggravation of pre-existing osteoarthritis by an accident-induced June 18, 2000 medial meniscus tear reached maximum medical improvement on October 4, 2001. At that time, the nature of his right knee injury changed from temporary to permanent.

Extent

The question of the extent of a disability, total or partial, is an economic as well as a medical concept. *Rinaldi v. General Dynamics Corp*., 25 BRBS 128, 131 (1991). The Act defines disability as an incapacity, due to an injury, to earn wages which the employee was receiving at the time of injury in the same or other employment. *McBride v. Eastman Kodak Co*., 844 F.2d 797 (D.C. Cir. 1988). Total disability occurs if a claimant is not able to adequately return to his pre-injury, regular, full-time employment. *Del Vacchio v. Sun Shipbuilding & Dry*

Dock Co., 16 BRBS 190, 194 (1984). A disability compensation award requires a causal connection between the claimant's physical injury and his inability to obtain work. The claimant must show an economic loss coupled with a physical and/or psychological impairment. *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Under this standard, a claimant may be found to have either suffered no loss, a partial loss, or a total loss of wage-earning capacity. Additionally, the employment-related injury need not be the sole cause, or primary factor, in a disability for compensation purposes. Rather, if an employment-related injury contributes to, combines with, or aggravates a pre-existing disease or underlying condition, the entire resultant disability is compensable. *Strachen Shipping v. Nash*, 782 F.2d 531 (5th Cir. 1986).

Based on the employment records in evidence, Mr. Kitano was out of work due to his right knee injury on June 19, 2000, June 20, 2000 and from February 16, 2001 to April 8, 2001. During these periods of lost time, the extent of Mr. Kitano's disability due to his right knee injury was total. Since these dates obviously preceded his reaching MMI, the nature of his disability during those periods was temporary. As a result, Mr. Kitano is entitled to temporary total disability compensation on June 19, 2000, June 20, 2000, and February 16, 2001 to April 8, 2001 at the stipulated weekly compensation rate of $225.32.[44] The record also establishes that the Employer has paid Mr. Kitano this stated disability compensation.

The central issue concerning the disability compensation for the right knee is the extent of Mr. Kitano's disability as of July 26, 2002 when he stopped working at the golf course.[45] That change in employment status and inability to earn wages might represent total disability.

To establish a *prima facie* case of total disability, whether temporary or permanent in nature, a claimant has the initial burden of proof to show that he cannot return to his regular or usual employment due to work-related injuries. *See Newport News Shipbuilding & Dry Dock Company v. Tann*, 841 F.2d 540, 542 (4th Cir. 1988). This evaluation of loss of wage earning capacity focuses both on the work that an injured employee is still able to perform and the availability of that type of work which he can do. *McBride*, 844 F.2d at 798. At this initial stage, the claimant need not establish that he cannot return to any employment, only that he cannot return to his former employment. *Elliot v. C & P Tel. Co*., 16 BRBS 89 (1984). A claimant's credible testimony of considerable pain while performing work may be a sufficient basis for a disability compensation even though other evidence indicates the claimant has the capacity to do certain types of work. *Mijangos v. Avondale Shipping, Inc*., 948 F.2d 194 (8th Cir. 1999); *Anderson v. Todd Shipyards Corp*., 22 BRBS 20 (1989).

As a first step in the analysis, I conclude that Mr. Kitano's part-time work as a golf cart attendant did not exceed Dr. Sandor's permanent work restrictions due to Mr. Kitano's right knee

[44]At the time of his June 18, 2000 accident, Mr. Kitano was working part-time and earning less than the National Average Weekly Wage during that period of $450.64. According to Section 6 (b) (2) of the Act, the minimum weekly disability compensation rate was $225.32. *See* http://www.dol.gov/esa/owcp/dlhwc/NAWWinfo.htm.

[45]Mr. Kitano's employment records also indicate the Employer paid temporary partial disability payments from April 9, 2001 to July 29, 2001 at the weekly rate of $61.32. Apparently, during this period, Mr. Kitano was not able to work the full 21 hours a week. The parties did not ask me to address that disability compensation.

injury. His attendant work did not require running or jumping. Based on the nature and frequency of the golf cart flat tires, the job only required occasional kneeling. Mr. Kitano's job description does not mandate long, uninterrupted periods of standing and walking. Notably, from mid-July 2001 to July 26, 2002, for a year, Mr. Kitano apparently was able to obtain sufficient breaks to tolerate the amounts of walking and standing that his job required. Finally, in terms of lifting, Mr. Kitano provided testimony that at times he exceeded his 25 pound lifting limitation. However, that choice appears to have been Mr. Kitano's and not directed by any supervisor. The golf course manager noted that two people are assigned to a shift at the golf cart barn and can assist each other lifting heavy objects. In this testimony, Mr. Kitano agreed that most of the time, he and his partner worked together to move the heavy items, such as the golf ball container.

On July 26, 2002, Dr. Hager stopped Mr. Kitano from working as a golf cart attendant due to worsening pain in his shoulder and knees. Had that medical determination been based on *credible* complaints of pain or other objective medical evidence, Mr. Kitano may have been able to establish a *prima facie* case of total disability. However, as I have stated in several ways, I believe Mr. Kitano's presentation to Dr. Hager was not credible. Again, the high pain levels Dr Hager recorded on July 26, 2002 to justify the removal from work are inconsistent with his presentation to Dr. Sandor in June 2002 and Mr. Kitano's physical activities observed on the August 12, 2002 videotape. Consequently, I find Dr. Hager's medical opinion predicated on Mr. Kitano's pain reports does not establish a *prima facie* case of total disability.

In April 2003, Dr. Okamura determined that Mr. Kitano was temporarily totally disabled. Since he based his opinion in part on Mr. Kitano's reports of worsening pain, his determination suffers the same probative deficiency as Dr. Hager's total disability diagnosis. Dr. Okamura's total disability finding is further diminished by a reasoning shortfall. Dr. Okamura premised his determination that Mr. Kitano was incapable of working on the assumption that he is being exposed to a 40 hour work week. Yet, Dr. Okamura acknowledged that when he first examined Mr. Kitano in July 2002, he believed Mr. Kitano could continue with his part-time work at the golf course. Due to these stated problems, I also consider Dr. Okamura's medical opinion insufficient to establish total disability.

As mentioned above, although Mr. Kitano's right knee may not by itself be totaling disabling, he may nevertheless have a compensable disability claim if his right knee injury combines with some other condition to preclude his ability to work. The other problems Mr. Kitano has are his non-work-related shoulder joint arthritis and his claimed left knee pain, which I will address next. Analysis of this potential avenue for finding total disability is cut short because once again the principal diagnostic tool utilized by Dr. Hager and Dr. Okamura is Mr. Kitano's complaints of pain.

In summary, due to my lack of confidence in the accuracy of Mr. Kitano's pain reporting, I find the medical opinions of Dr. Hager and Dr. Okamura insufficient proof that Mr. Kitano can no longer perform his part-time work as a golf course attendant. Accordingly, the extent of Mr. Kitano's right knee disability is at best partial, not total.

Permanent Partial Disability Compensation

In light of my determinations, on October 4, 2001, the nature of Mr. Kitano's right knee disability due to his June 18, 2000 accident became permanent and its extent is partial. Thus, Mr. Kitano has suffered a permanent partial disability involving a component of his right leg and he is entitled to permanent partial disability compensation for a scheduled injury under the Act.

The method and amount of the actual compensation for a permanent partial disability is established by Section 8 (c) of the Act, 33 U.S.C. § 908 (c). In the first portion of this section, Sections 8 (c) (1) to (c) (17), compensation for numerous types of injuries, such as loss of a leg, is established by a specific schedule of awards. For other injuries not listed in this schedule, such as a back injury, Section 8 (c) (21) bases permanent partial disability compensation on two-thirds the difference between the average weekly wage of the employee and the employee's wage-earning capacity thereafter in the same or another employment.

Although the first 17 subparagraphs address the total loss of a specified limb, an eye or hearing, Section 8 (c) (19) provides that partial loss of use of a limb is compensated as a proportional loss of use of the limb. The Benefit Review Board and the courts apply the proportionality principle set out by Section 8 (c) (19) for a partial loss of use by indicating the compensation runs for the proportionate number of weeks attributable to the loss of the member at the full compensation rate of two-thirds of the average weekly wage. *Nash v. Strachan Shipping Co.*, 15 BRBS 386 (1983), *aff'd in relevant part but rev'd on other grounds*, 760 F.2d 569 (5th Cir. 1985), *aff'd on recon en banc,* 782 F. 2d 513 (1986).

For an injury listed on the schedule, the injured employee is automatically entitled to a certain level of compensation as a result of his injury and no proof of actual wage-earning capacity is required to receive the specified compensation. *See Travelers Ins. Co*., 225 F.2d 137 (2d Cir.) *cert. denied* 350 U.S. 913 (1955). As a result, the adjudication of a permanent partial disability under the schedule is based solely on physical factors. *Bachich v. Seatrain Terminals*, 9 BRBS 184, 187 (1978). In determining the appropriate degree (or proportionate) loss of use in a permanent disability compensation case, the Benefits Review Board in *Peterson v. Washington Metro. Area Transit Auth*. 13 BRBS 891, 897 (1981), stated an administrative law judge "is not bound by any particular formula when determining the degree of permanent partial disability and that it is within his discretion to assess a degree of disability different from the ratings found by the physicians if that degree is reasonable." Finally, a knee injury is adjudicated under Sections 8 (c) (2) and (c) (19) of the Act as partial loss of use of the leg. *Nash,* 15 BRBS at 391.

At the hearing, when questioned about rating a disability attributable to Mr. Kitano's right knee, Dr. Hager set out three considerations under the Fifth Edition of the AMA Impairment Guide: arthritis, Mr. Kitano's altered gait, and his mild loss of cartilage. However, because he did not have the guide at hand, Dr. Hager was unable to state a specific percentage disability. When Dr. Smith addressed the same issue, he stated that under the guide, Mr. Kitano would have a two percent lower extremity impairment due to the partial medial meniscectomy on the right knee.

Based on this sparse medical information, I concluded that at a minimum, due to the June 18, 2000 accident and subsequent corrective surgery on his right knee, Mr. Kitano has suffered a two percent loss of use of his right leg. Consequently, he is entitled permanent partial disability compensation under Sections 8 (c) (2) and (19) for a permanent 2% loss of use of his right leg due to the June 18, 2000 accident. The applicable weekly compensation rate is the stipulated rate of $255.32.

Penalties

At the hearing, Mr. Birnbaum raised the issue of penalties associated with any ratable impairment to the right knee. He stated that "there is a ratable impairment and it has not been paid within 14 days. We are raising the issue of penalties." Mr. Kessner responded that the Employer asserts any ratable disability is due to a "pre-existing condition." (TR, page 24).

Section 14 (e) imposes a 10% penalty on overdue payment payable without an award if the payment is not made within 14 days after it becomes due. Additionally, Section 14 (e) suspends any penalties if a timely controversion has been filed under Section 14 (d). Such controversion is timely if an Employer submits the controversion within 14 days after it has knowledge of the alleged injury. Based on this language, the starting point for liability is 28 days[46] after the employer is aware of the injury. *DeRoberts v. Oceanic Container Service*, 14 BRBS 284 (1981). The duration of liability under Section 14 (e) ceases on the date of the filing of the notice of controversion. *National Steel & Shipbuilding Co. v. U.S. Dep't of Labor*, 606 F.2d 875 (9th Cir. 1979) *aff'g in part and rev'g in part Holston v. National Steel & Shipbuilding Co.*, 5 BRBS 794 (1977). In Section 8 (c) scheduled injury cases, where a claimant loses no time from work or has returned to work and the parties wait in good faith to determine the permanency or extent of partial impairment under the schedule, an employer has 14 days after receiving knowledge of the permanency of the claimant's condition and/or the extent of his impairment to controvert liability for the scheduled injury. In the absence of a timely controversion, liability for additional compensation occurs fourteen days after the close of the fourteen day controversion filing period. *DeRoberts*, 14 BRBS at 289.

On June 18, 2000, Mr. Kitano injured his right knee. On June 23, 2000, in filing a Notice of Injury, the Employer acknowledged awareness of the injury. Between June 19, 2000 and July 29, 2001, the Employer rendered voluntary temporary total and temporary partial disability compensation to Mr. Kitano. On April 9, 2001, Mr. Kitano returned to work. On October 16, 2001, Mr. Kitano filed a claim for disability compensation for his right knee injured on June 18, 2000. On October 26, 2001, Dr. Sandor notified the Employer that Mr. Kitano's right knee disability became permanent and indicated that the disability was ratable. The Employer's controversion of the claim was submitted on September 3, 2002.

In light of the principles and facts noted above, I find the Employer became aware of the permanency of Mr. Kitano's right knee disability on October 26, 2001. Since the Employer did not file a controversion within 14 days, its liability under Section 14 (e) commenced on November 23, 2001, twenty-eight days after the notification of Mr. Kitano's permanent disability

[46]After the fourteen days provided to the Employer to controvert an injury, the disability payment becomes due. Another fourteen days later, the payment is overdue and penalties are initiated.

and continued until the Employer filed a controversion on September 3, 2002. Accordingly, Mr. Kitano is entitled to additional compensation in the form of penalties assessed under Section 14 (e) for the amount due for his permanent partial disability from November 23, 2001 to September 3, 2002.

Issue No. 2 – Medical Benefits[47]

Under Section 7 (a) of the Act, if an employer is found liable for the payment of disability compensation, then the employer is also responsible for those reasonable and necessary medical expenses incurred as a result of a work-related injury. *Perez v. Sea-Land Services, Inc.*, 8 BRBS 130 (1978). Entitlement to medical services is never time-barred where a disability is related to a compensable injury. *Colburn v. General Dynamics Corp.*, 21 BRBS 219 (1988). Under this section, a claimant is entitled to reimbursement for reasonable travel expenses in seeking medical care and treatment for his work-related injury. *Tough v. General Dynamics Corp.,* 22 BRBS 356 (1989).

On June 18, 2000, Mr. Kitano suffered a compensable injury which resulted in temporary total, temporary partial, and permanent partial disability compensation. I have determined that Mr. Kitano has reached MMI based on Dr. Sandor's opinion, which means his aggravated arthritis condition has reached the maximum benefits associated with extensive medical treatment and testing. Nevertheless, Mr. Kitano may still struggle with some residual difficulties, albeit not at his stated pain levels. Accordingly, I find Mr. Kitano remains entitled to reasonable and necessary medical expenses associated with providing relief for right knee aggravated arthritis discomfort. Such medical care includes reasonable and necessary periodic physician consults, pain management procedures, and medication.

D. Left Knee/Cumulative Bilateral Knee Injury

The other half of Mr. Kitano's cumulative bilateral knee injury claim involves the left knee. Due to the injuries he suffered to his right knee on June 18, 2000, Mr. Kitano claims he placed more stress on his left knee to the extent that he has suffered a cumulative injury to, and disabling pain in, his left knee. The Employer asserts Mr. Kitano's disability compensation claim for his left knee is untimely and additionally contests causation, extent and nature of disability, disability compensation, and medical benefits.

Issue No. 1 – Timely Notice of Claim

The Employer asserts that Mr. Kitano's claim for total disability due to his left knee as of May 2002 is untimely because he did not present the claim until the May 12, 2003 hearing.

To review, under Section 13 (a), as judicially interpreted, a disability compensation claim must be filed within one year after both the relationship between the disability and injury, and

[47]During his hearing testimony, Mr. Kitano mentioned that he was having some trouble with a medical bill associated with his right knee surgery. The amount in dispute was $82. Since the record contained no other information about this billing dispute, I am unable to ascertain whether it involves a reimbursable medical expense.

the disability's adverse impact on earning power are known.[48] Although Mr. Kitano presented his left knee pain complaints to Dr. Sandor in the spring of 2002 and Dr. Hager in May 2002, the potential adverse impact on wages was not known to Mr. Kitano until Dr. Hager stopped him from working on July 26, 2002. Thus, since the hearing occurred less than one year later, even if Mr. Kitano's presentation at the proceeding represents the first time he claimed total disability compensation for his left knee, it is a timely claim.

Also, the record indicates the Employer was aware of Mr. Kitano's left knee disability claim prior to the hearing. In an August 2002 informal conference, the parties discussed Mr. Kitano's various claims, including the claim for his left knee. On September 3, 2002, the Employer controverted liability of the claims presented at the informal conference. And, in the Claimant's September 11, 2002 pre-hearing statement, his counsel referenced disability claims for various parts of Mr. Kitano's body and specifically included the left knee.

Issue No. 2 – Causation

Having determined Mr. Kitano has presented a timely claim for disability compensation associated with his left knee, I now turn to the issue of whether his left knee condition in May 2002 is work-related.

Background and Medical Opinion

Mr. Kitano testified that his left knee gets tired. He doesn't really have any problems with it, but when he relies too much on the left knee, it tires. The condition is intermittent and once in a while he experiences pain.

Although Mr. Kitano first saw Dr. Sandor within weeks of his June 2000 accident, he did not present any left knee pain complaints until October 4, 2001. At that time, according to Mr. Kitano, his limping due to the right knee had placed additional stress on the left knee and caused discomfort. Upon examination, Dr. Sandor found no effusion. Dr. Sandor diagnosed the left knee pain as a secondary symptom to his altered gait. At the same time, finding that the right knee medial meniscus had reached maximum medical improvement, Dr. Sandor issued work restrictions in light of Mr. Kitano's knee aggravation due to the meniscus injury. In January 2002, Mr. Kitano reported his left knee hurt. Again, Dr. Sandor found no effusion. Dr. Sandor's treatment notes from March, June and October 2002 do not contain a reference to left knee pain. Following these later examinations, Dr. Sandor did not alter his permanent work restrictions.

On May 14, 2002, Mr. Kitano told Dr. Hager that he developed left knee pain due to shifting his weight away from his injured right knee. In the corresponding treatment note, Dr. Hager recorded that the pain was worse in his right knee. In his deposition, Dr. Hager recalled the presenting pain levels were 8 for the right knee, 5 for the left knee. Yet, during the hearing, Dr. Hager stated that Mr. Kitano first indicated the pain was worse in the left knee than the right knee. Dr. Hager noted some medial line tenderness and effusion in the left knee. On July 26, 2002, Mr. Kitano told Dr. Hager that the pain level in his left knee had worsened. Since Mr. Kitano was on his feet all day and Dr. Hager was uncertain about the cause of the worsening

[48] *See* page 46.

condition, he stopped Mr. Kitano from working. In January and February 2003, Mr. Kitano described the pain level in his left knee as 6; the right knee pain was at 8. Mr. Kitano had full range of motion in the left knee with pain. Some tenderness and effusion was present on the medial joint line. Dr. Hager diagnosed post-traumatic osteoarthritis in both knees and later stated he suspected a torn medial meniscus in the left knee. In March 2003, Mr. Kitano reported a pain level of 3 for his left knee. According to Dr. Hager, the left knee problem is related to the right knee condition. In response to the right knee injury, Mr. Kitano has placed a greater load on his left knee. Because the left knee has not been fully evaluated, it is not at MMI.

In July 2002, Mr. Kitano presented to Dr. Okamura with bilateral shoulder and knee pain. He indicated that the pain was greater in the left knee than the right knee. He had been favoring his right knee following surgery and placing more pressure on his left knee. The knee's range of motion was limited by pain and was tender on the medial side. Dr. Okamura diagnosed bilateral knee arthritis and "possible left knee meniscus tear." In April 2003, Mr. Kitano reported that his right knee was more troubling than his left knee. Dr. Okamura found no effusion in the left knee. Dr. Okamura recalled that a 2002 x-ray of the left knee showed some medial joint narrowing and he believed the knee had some arthritic changes. That pre-existing condition would make it more likely that the left knee would develop symptoms. Due to the possible medial meniscus tear, Dr. Okamura recommends an arthrogram. He believes that the injury to Mr. Kitano's right knee has accelerated the development of symptoms in his left knee. Mr. Kitano's left knee condition involves a combination of arthritis and possible meniscus tear. Pending additional diagnostic tests, Mr. Kitano's left knee is not at MMI and has not received all available treatment. He is temporarily totally disabled due to his knees. Dr. Okamura acknowledged that he has not observed the surveillance video. Work restrictions associated with the knees include squatting and jumping. Carrying light loads would not be a problem. Upon his first visit, Dr. Okamura believed Mr. Kitano could work part-time with his conditions, including his left knee problem.

According to Dr. Smith, Mr. Kitano's left knee condition involves genetic and age-related osteoarthritis and degenerative joint disease. That condition pre-dated any purported change in Mr. Kitano's gait. Any relationship between his left knee condition and right knee problem is dubious. The left knee is at MMI. When he examined Mr. Kitano in March 2003, the principal knee pain was located in the right knee. Although he was slow, Mr. Kitano walked normally. Radiographic studies of the left knee in July 2002 and April 2003 indicated some mild narrowing of the medial joint space, consistent with degeneration and indicative of osteoarthritis, which Dr. Smith believed was normal for Mr. Kitano's age. Mr. Kitano claims his left knee pain developed in October 2001 because he had been favoring his right knee after the knee surgery. Upon examination, no effusion was present and both knees were stable and symmetrical in size, strength and tone. He noted some range of motion limitation but considered them within normal limits. Dr. Smith noted that in the videotape, Mr. Kitano's symptoms evaporated. Mr. Kitano may believe that the soreness in his left knee is due to increased use due to his right knee problem. Dr. Smith disagrees with his presumption. In Dr. Smith's opinion, Mr. Kitano is merely experiencing the consequences of osteoarthritis in his left knee, which is less severe than the arthritis in the right knee and does not require medical treatment. His left knee has no impairment and its condition does not preclude Mr. Kitano's return to work.

Injury

As discussed earlier, my analysis starts with a determination of whether Mr. Kitano has an injury to his left knee. Again, during this inquiry the Section 20 (a) presumption does not assist Mr. Kitano.[49] Instead, he must establish that something has gone wrong with his left knee by a preponderance of the evidence.

The diverse medical opinions present the possibility that two things may have gone wrong with Mr. Kitano's left knee. First, based on Mr. Kitano's report of medial line tenderness in his left knee, Dr. Okamura diagnosed a "possible" medial meniscus tear and Dr. Hager suspected a left torn medial meniscus. As previously discussed, the "possibility," or suspicion, of an injury represents insufficient proof of its presence. Even if I considered the consensus diagnosis by Dr. Okamura and Dr. Hager to be definite, their opinion is offset by the contrary assessments of Dr. Sandor and Dr. Smith, the other two physicians who evaluated Mr. Kitano's left knee pain complaint. Neither Dr. Sandor nor Dr. Smith reported finding a medial meniscus tear injury in the left knee. Additionally, as previously noted, I believe Dr. Sandor's status as treating physician from just days after the June 18, 2000 accident to the fall of 2002 enhances the probative value of his assessment. As a result, I find the preponderance of the more probative medical opinion outweighs the equivocal findings of Dr. Okamura and Dr. Hagar. Consequently, Mr. Kitano has failed to prove that his left knee injury consists of a meniscus tear.

The second possible injury relates to aggravation or acceleration of left knee arthritis. Dr. Hager diagnosed post-traumatic osteoarthritis. Dr. Okamura diagnosed acceleration of Mr. Kitano's left knee arthritis. Dr. Sandor diagnosed left knee pain. While suspicious of Mr. Kitano's reporting accuracy, Dr. Smith didn't directly refute the presence of left knee pain. Both Dr. Okamura and Dr. Smith also noted radiographic evidence of degenerative arthritis in Mr. Kitano's left knee. This time, to the extent that Dr. Smith's assessment represents a finding of no left knee pain, I conclude that the opinions of Dr. Hager, Dr. Okamura, and Dr. Sandor, coupled with the radiographic evidence establishes that something has gone wrong with Mr. Kitano's left knee by October 2001 in the form of arthritis.

Causation

Returning to the familiar causation analysis, having establish the presence of some dysfunction in his left knee, I find Mr. Kitano is able to raise the Section 20 (a) causation presumption under two, separate causation possibilities. The first causation explanation relates to the nature of Mr. Kitano's work. As a golf cart attendant, Mr. Kitano engaged in some repetitive physical activities that could cumulatively stress and consequently aggravate or accelerate his left knee arthritis.[50]

The second causation possibility exists based on the relationship between Mr. Kitano's June 18, 2000 right knee injury involving a torn medial meniscus and aggravation of his pre-

[49]*See* page 50.

[50]No physician suggested that Mr. Kitano's employment caused his left knee arthritis. Dr. Hager's reference to post-traumatic arthritis reflects his belief that the left knee arthritis was affected by the trauma to the right knee.

existing right knee osteoarthritis and the subsequent dysfunction in his left knee. Following corrective surgery, Mr. Kitano's gait was altered. If that change in his walking also adversely affected his left knee, the left knee condition would be considered a natural consequence of a work-related injury. *See Uglesich v. Stevedoring Servs. Of America*, 24 BRBS 180 (1981) (according to the Benefits Review Board, if a claimant suffers a work-related injury to the right knee and as a consequence stresses and adversely affects the left knee, the condition of the left may be considered a natural and unavoidable consequence of the injury to the right knee, thereby becoming a work-related injury).

Once again, Dr. Smith's opinion that the current state of Mr. Kitano's left knee is normal for a man of Mr. Kitano's age rebuts the causation presumption. Consequently, Mr. Kitano must establish causation by a preponderance of the evidence.

In regards to cumulative aggravation of his left knee arthritis directly due to his employment, I find little probative evidence to supports such a finding. Prior to the June 2000 accident, Mr. Kitano had no problems with either knee. After the accident and injury to his right knee, Mr. Kitano did not attribute the development of his left knee pain to work itself. Instead, he always believed his problem was due to favoring his injured right knee. Considered another way, the record contains insufficient evidence that Mr. Kitano would have experienced aggravated left knee arthritis in October 2001 in the absence of the June 2000 right knee injury.

In October 2001, Mr. Kitano presented for the first time his complaint of left knee pain due to his altered gait. Dr. Sandor noted the changed gait, examined the left knee and diagnosed left knee pain as a consequence of Mr. Kitano's altered gait. Dr. Hager agrees with the relationship between Mr. Kitano's left knee pain and his right knee injury. Dr. Okamura essentially concurs, observing the radiographic evidence of degenerative changes in the left knee predisposed the knee to the development of symptoms due to increased stress on the left knee. I find this medical consensus, and in particular Dr. Sandor's diagnosis, more probative than Dr Smith's contrary opinion. Accordingly, Mr. Kitano has proven that he suffered left knee pain due to aggravation of his pre-existing left knee arthritis as natural consequence of his June 18, 2000 right knee injury.

Issue No. 3 – Nature and Extent of Disability

Concerning the nature of Mr. Kitano's left knee disability, for the same reasons previously discussed in regards to the aggravated arthritis in the right knee, I find Dr. Sandor's assessment more probative than the opinions of Dr. Hager and Dr. Okamura on the issue of MMI. Principally, because Mr. Kitano's reported pain levels are suspect and the August 2002 videotape shows no apparent dysfunction of his left knee, I find Dr. Hager and Dr. Okamura based their MMI determinations on inaccurate pain level documentation. In contrast, based on Dr. Sandor's familiarity with the condition of Mr. Kitano's knee from nearly the day of the accident, through the post-surgery recovery and into October 2002, I give his assessment on the state of Mr. Kitano's knees greater probative weight. Specifically, Dr. Sandor noted in June 2002 that Mr. Kitano was tolerating work well and that in October 2002, the only reported pain involved the right knee. Finally, I observe that at the May 2003 hearing, Mr. Kitano testified that he really doesn't have any problems with his left knee other than fatigue. Consequently, I find

the preponderance of the more probative medical evidence establishes that Mr. Kitano's left knee injury consisting of aggravation of pre-existing arthritis due to his altered gait stemming from the June 18, 2000 right knee injury reached maximum medical improvement, along with the right knee, on October 4, 2001. At that time the nature of his left knee injury became permanent.

Considering the extent of the left knee injury, the record contains no evidence of lost work associated with Mr. Kitano's left knee pain through July 26, 2002. Additionally, as I have previously determined, for the period after July 26, 2002, Mr. Kitano has failed to prove that he is totally disabled due to his right knee and other combinations of problems because the principal means to establish his inability to work are his pain level complaints which are not credible. When the left knee pain is added as a contributing factor, the determination remains the same. Dr. Hager removed Mr. Kitano from work on July 26, 2002 in part due to worsening pain in his left knee. His reliance of Mr. Kitano's pain reporting undermines his assessment of Mr. Kitano's capacity to work. Dr. Okamura likewise relied on Mr. Kitano's pain complaints; he also inconsistently permitted Mr. Kitano to return to his part-time work in July 2002. Thus, since Mr. Kitano has failed to prove total disability, the extent of his left knee injury is partial.

Concerning compensation for his permanent partial left knee injury, no physician has presented an opinion that Mr. Kitano suffered a partial loss of use of his left leg. In the absence of any medical finding of an impairment to the functional use of his left leg due to his aggravated pre-existing arthritis, any claim for permanent partial disability compensation for the left knee pain in October 2001 must be denied.

Issue No. 4 – Medical Benefits

Even though Mr. Kitano is not entitled to disability benefits, he may nevertheless receive medical benefits for his compensable left knee work-related injury to the extent such treatment is reasonable and necessary. *See Ingalls Shipbuilding, Inc. v. Director, OWCP,* 991 F.2d 163 (5th Cir. 1003) and *Pernell v. Capitol Hill Masonry,* 11 BRBS 532, 539 (1979). Such treatment must be appropriate for his injury which consists of left knee pain attributable to pre-existing arthritis to the extent it has been aggravated by Mr. Kitano's altered gait due to his right knee injury. The Employer's obligation to provide such medical benefits continues for such period as the nature of his left knee injury may require. *See* 20 C.F.R. § 702.402

ATTORNEY FEE

Section 28 of the Act, 33. U.S.C. § 928, permits the recoupment of a claimant's attorney's fees and costs in the event of a "successful prosecution."[51] Since I have determined issues in favor of Mr. Kitano, his attorney, Mr. Birnbaum, is entitled to submit a petition to recoup his fees and costs associated with his professional work before the Office of Administrative Law Judges. Mr. Birnbaum has thirty days from receipt of this decision and order to file an application for attorney fees and costs as specified in 20 C.F.R. § 702.132 (a).

[51]Since Mr. Kitano was only partially successful, both parties must address the application of the analysis set out by the U.S. Supreme Court, in *Hensley v. Eckerhart,* 461 U.S. 424 (1983), made applicable to longshoreman claims in *George Hyman Const. Co. v. Brooks*, 963 F.2d 1532 (D.C. Cir. 1992).

The other party, and its counsel, Mr. Kessner, has ten days from receipt of such fee application to file an objection to the request.

ORDER

Based on my findings of fact, conclusions of law, and the entire record, I issue the following order. The specific dollar computations of the compensation award shall be administratively performed by the District Director.

1. The claim of MR. GEORGE T. KITANO for disability compensation and medical benefits for a right shoulder injury in May 2002 is **DENIED**.

2. The claim of MR. GEORGE T. KITANO for disability compensation and medical benefits for a left shoulder injury in May 2002 is **DENIED**.

3. The claim of MR. GEORGE T. KITANO for disability compensation and medical benefits for cumulative bilateral shoulder injury in May 2002 is **DENIED**.

4. The Employer, MARINE CORPS MWR, **SHALL PAY** the Claimant, MR. GEORGE T. KITANO, compensation for **TEMPORARY, TOTAL DISABILITY**, for June 19, 2000, June 20, 2000, and from February 16, 2001 to April 8, 2001, at the stipulated weekly compensation rate of $225.32, for a right knee injury caused by a June 18, 2000 accident, in accordance with Section 8 (b) of the Act, 33 U.S.C. § 908 (b).

5. The Employer, MARINE CORPS MWR, **SHALL PAY** the Claimant, MR. GEORGE T. KITANO, compensation for **PERMANENT PARTIAL DISABILITY** due to a permanent 2% loss of use of his right leg caused by a right knee injury in a June 18, 2000 accident, as of October 4, 2001, based on a stipulated weekly compensation rate of $225.32, in accordance with Section 8(c) (2) and Section 8(c) (19) of the Act, 33 U.S.C. §§ 908 (c) (2) and 980 (c) (19).

6. The Employer, MARINE CORPS MWR, **SHALL PAY** the Claimant, MR. GEORGE T. KITANO, **ADDITIONAL COMPENSATION** for the overdue permanent partial disability payment established in paragraph 5 of this order, for the period November 23, 2001 to September 3, 2002, such compensation to be computed in accordance with Section 14 (e) of the Act, 33 U.S.C. § 914 (e).

7. The Employer, MARINE CORPS MWR, **SHALL FURNISH** to the Claimant, MR. GEORGE T. KITANO, such reasonable, appropriate, and necessary **MEDICAL CARE AND TREATMENT** as his right knee injury caused by a June 18, 2000 accident may require in accordance with Section 7 (a) of the Act, 33 U.S.C. § 907 (a).

8. The claim of MR. GEORGE T. KITANO for disability compensation for a left knee injury that arose in October 2001 as a natural consequence of his right knee injury caused by a June 18, 2000 accident is **DENIED**.

9. The Employer, MARINE CORPS MWR, **SHALL FURNISH** to the Claimant, MR. GEORGE T. KITANO, such reasonable, appropriate, and necessary **MEDICAL CARE AND TREATMENT** as his left knee injury that arose in October 2001 as a natural consequence of his right knee injury caused by a June 18, 2000 accident may require in accordance with Section 7 (a) of the Act, 33 U.S.C. § 907 (a).

10. The Employer, MARINE CORPS MWR, **SHALL RECEIVE CREDIT** for all amounts of disability compensation previously paid to the Claimant, MR. GEORGE T. KITANO as a result of injuries in a June 18, 2000 accident.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: July 9, 2004
Washington, DC

Attachment No. 1

American Board of Medical Specialties

Certification:

John M. Sandor, MD

Certified by the American Board of Family Practice Surgery in:

Family Practice

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://abms.org

Attachment No. 2

American Board of Medical Specialties

Certification:

Jerry W. Van Meter, MD

Certified by the American Board of Orthopaedic Surgery in:

Orthopaedic Surgery

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://abms.org